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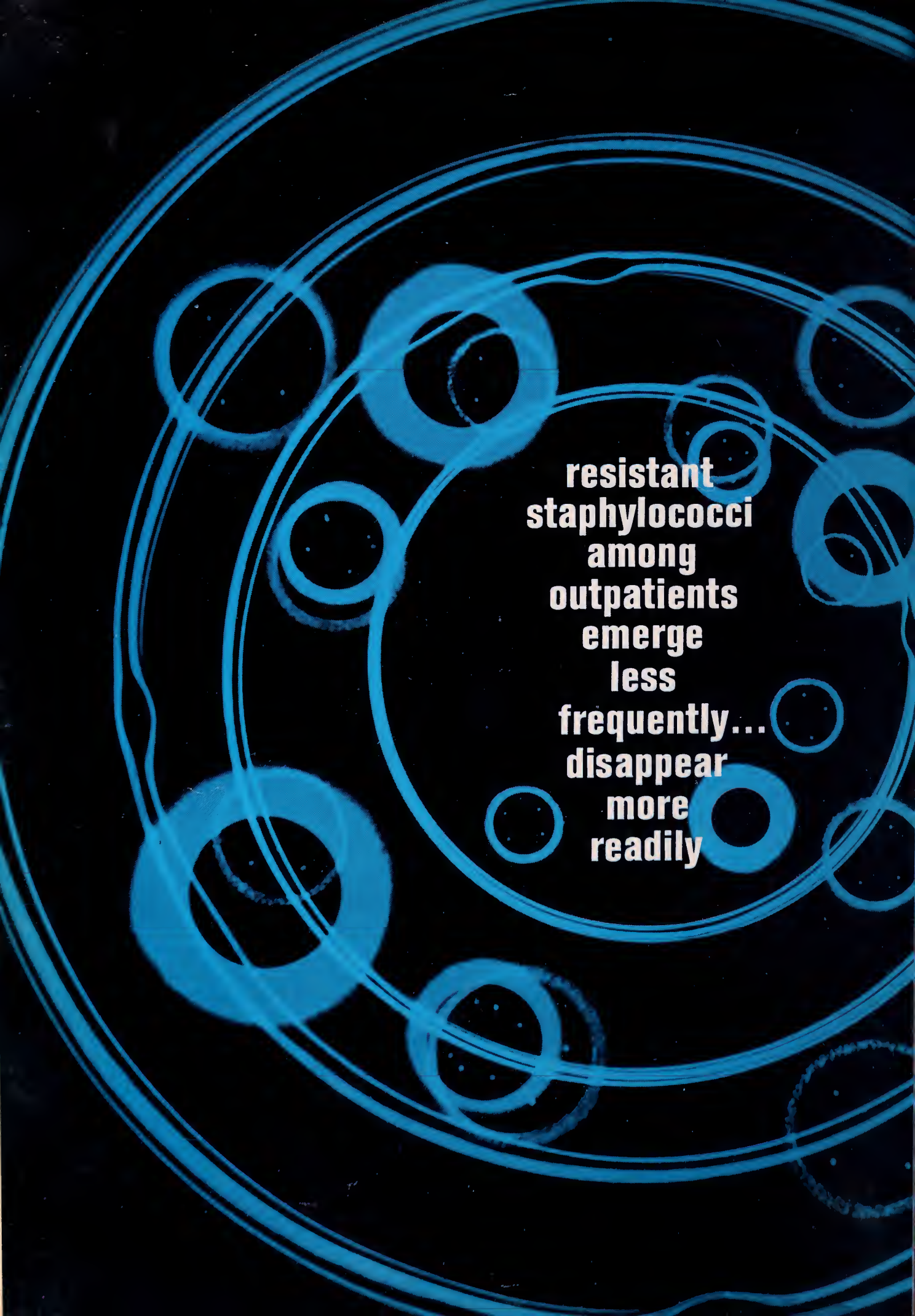
THE Journal OF THE FLORIDA MEDICAL ASSOCIATION

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ICIAL PUBLICATION
OF THE
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resistant
staphylococci
among
outpatients
emerge
less
frequently...
disappear
more
readily

CHLOROMYCETIN®

chloramphenicol, Parke-Davis

"Resistance to chloramphenicol was surprisingly infrequent (0-5%)" among strains of staphylococci isolated from outpatients over a 5-year period. It was impressive to note that less than 6% of 310 strains isolated from patients treated in the emergency room were resistant to CHLOROMYCETIN. Moreover, it would appear "...that chloramphenicol-resistant staphylococci disappear more readily after leaving the hospital environment."[1]

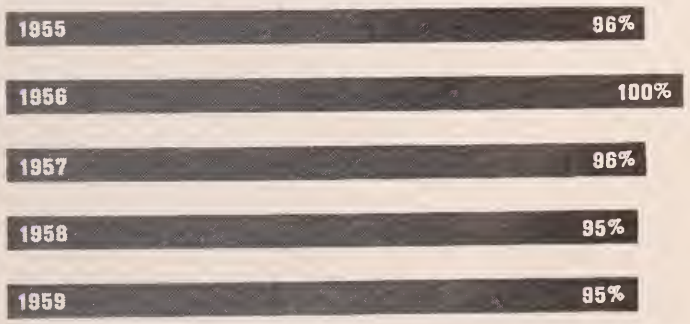
Goslings and Büehli[2] report that "...resistance was lost entirely after 3 months..." in the small percentage of patients who carried staphylococcal strains resistant to CHLOROMYCETIN. Numerous other investigators concur in the observation that staphylococcal resistance to CHLOROMYCETIN is of a low order.[3-8]

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References: (1) Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* 173:475, 1960. (2) Goslings, W. R. O., & Büchli, K.: *Arch. Int. Med.* 102:691, 1958. (3) Goodier, T. E. W., & Parry, W. R.: *Lancet* 1:356, 1959. (4) Fisher, M. W.: *Arch. Int. Med.* 105:413, 1960. (5) Petersdorf, R. G., *et al.*: *Arch. Int. Med.* 105:398, 1960. (6) Glas, W. W., in Symposium on Antibacterial Therapy, Michigan & Wayne County Acad. Gen. Pract., Detroit, September 12, 1959, p. 7. (7) Modarress, Y.; Ryan, R. J., & Francis, Sr. C. F.: *J. M. Soc. New Jersey* 57:168, 1960. (8) Rebhan, A. W., & Edwards, H. E.: *Canad. M. A. J.* 82:513, 1960.

IN VITRO SENSITIVITY OF COAGULASE-POSITIVE STAPHYLOCOCCI TO CHLOROMYCETIN FROM 1955 TO 1959*



These sensitivity tests were done by the disc method on 310 strains of coagulase-positive staphylococci. Strains were isolated from patients seen in the emergency room. It should be noted that among inpatients, resistant strains were considerably more prevalent.

*Adapted from Bauer, Perry, & Kirby[1]

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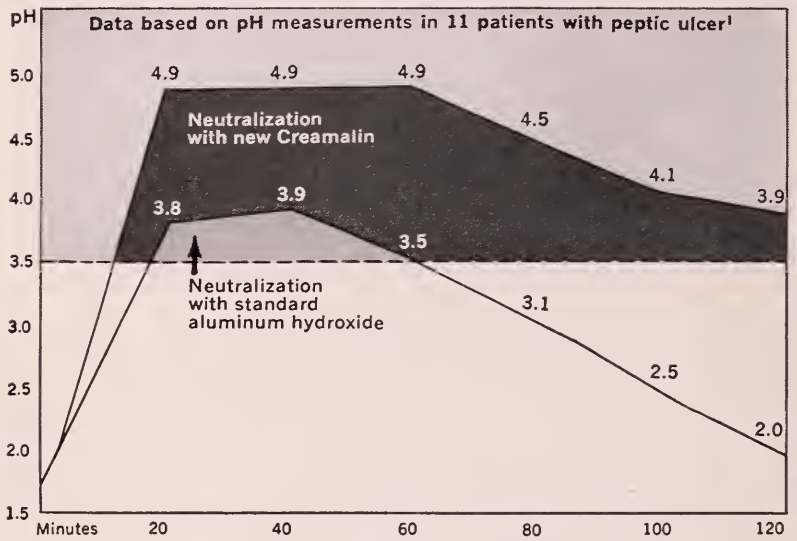
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1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

Winthrop LABORATORIES
New York 18, N. Y.

for peptic ulcer ■ gastritis ■ gastric hyperacidity

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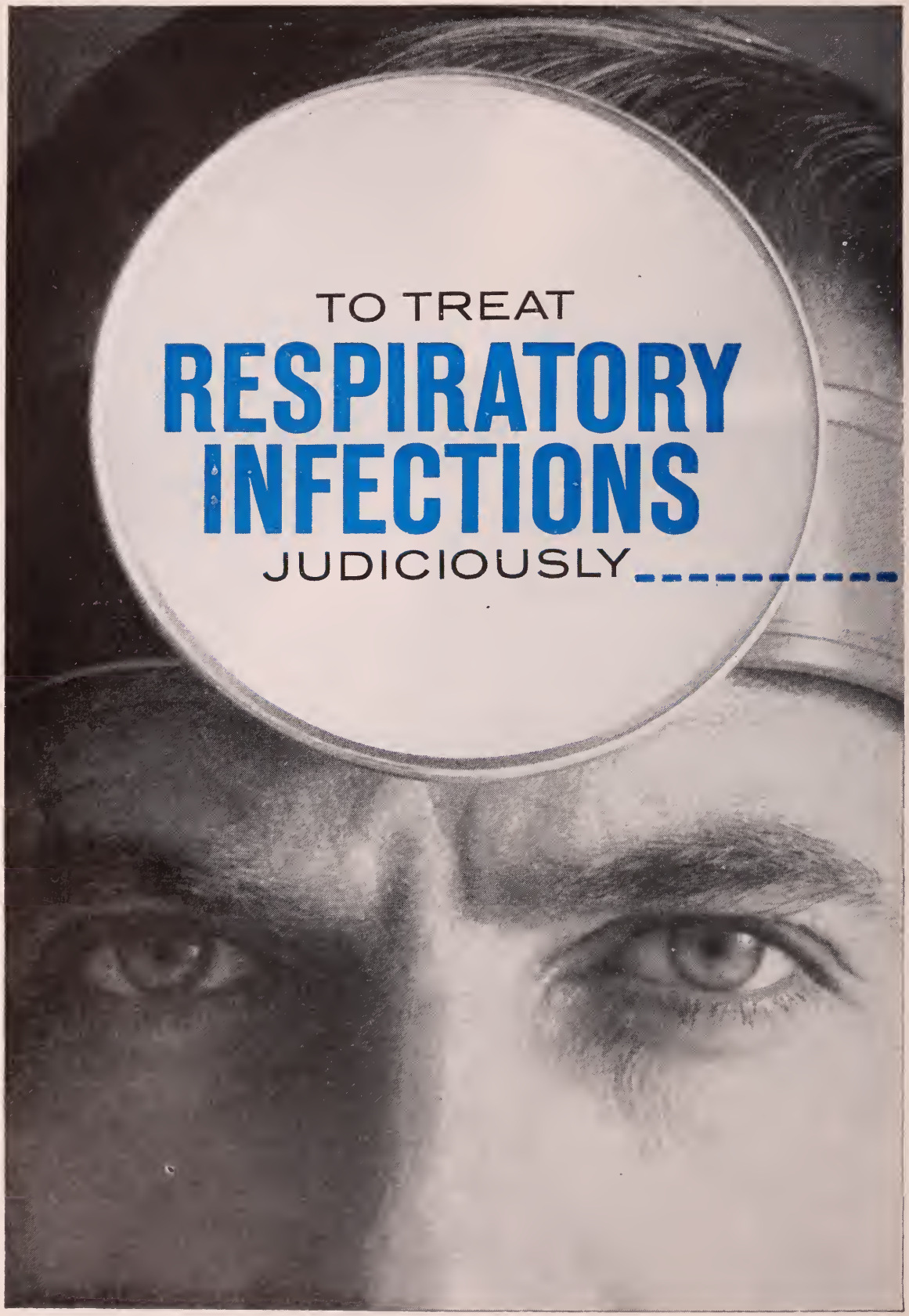
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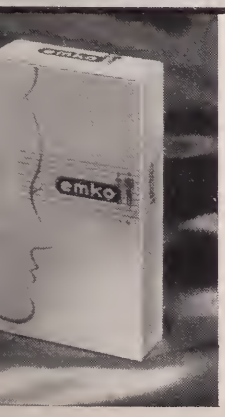
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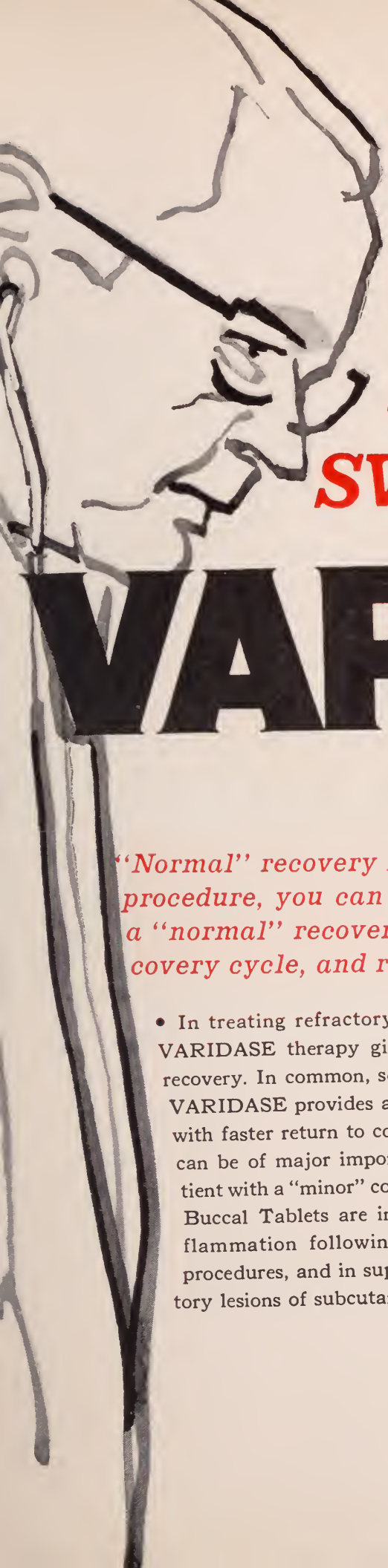
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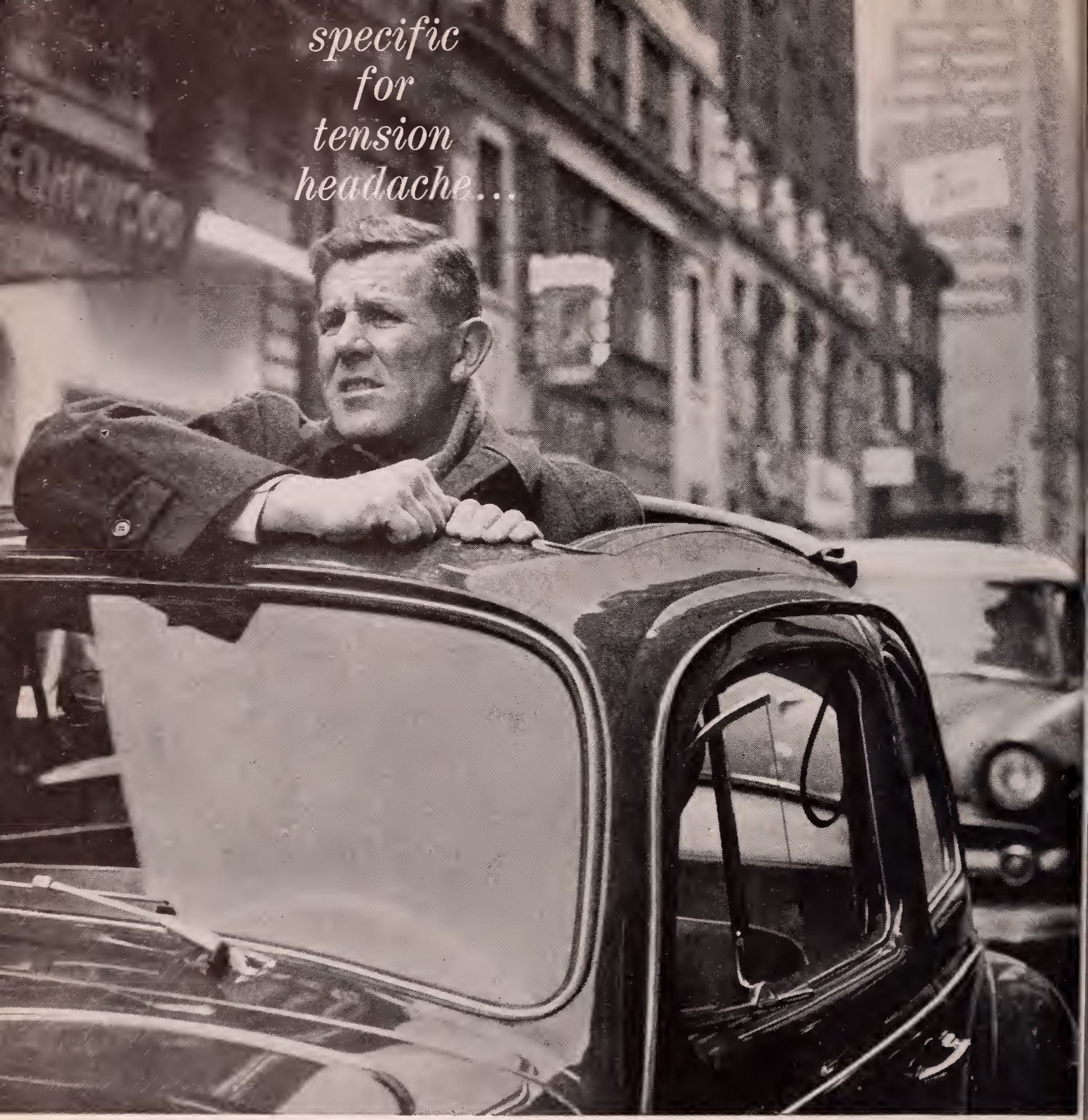
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Friedman, A. P., and Merritt, H. H.: J.A.M.A. *163*:1111 (Mar. 30) 1957.

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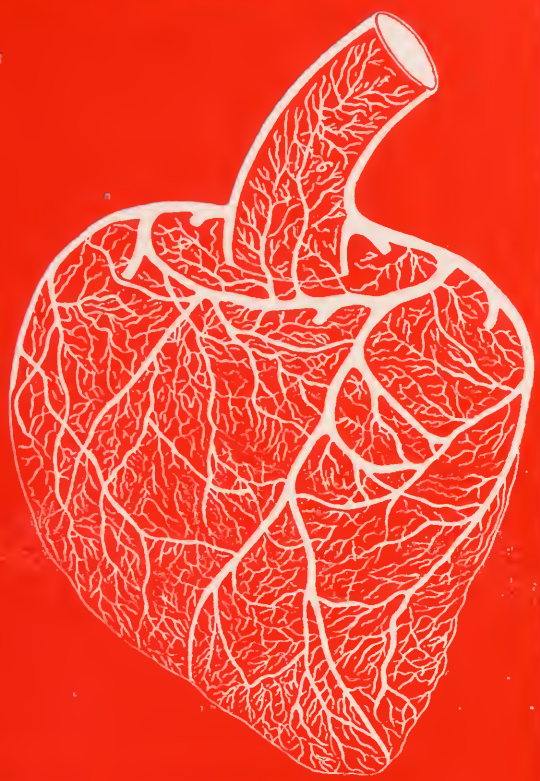
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*Clark, T. E., in press.

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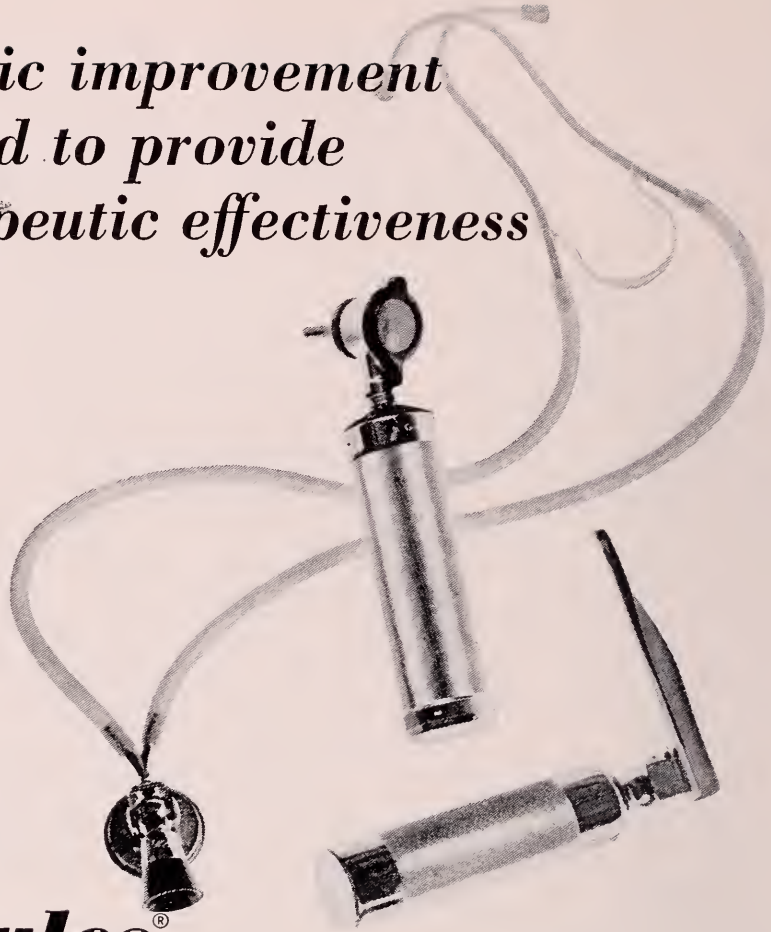
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2. Salitsky, S., *et al.:* Antibiotics Annual, p. 893, 1959-1960.
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4. Kuder, H. V.: Clin. Pharmacol. & Therap., in press.

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THE JOURNAL
OF THE
FLORIDA MEDICAL ASSOCIATION
Volume XLVII, No. 7, January, 1961

Carcinoma of the Cervix

A Clinical Review of the Treatment and Results in 215 Cases

CURTIS W. CANNON, M.D., HOWARD C. DUCKETT JR. M.D.,
AND JEAN B. WILLIAMS JR., M.D.
JACKSONVILLE

The Gynecological Tumor Clinic was established at the Duval Medical Center in 1957. At that time a review of the records of patients treated for carcinoma of the cervix was begun. This report deals with a total of 215 patients with invasive carcinoma of the cervix who were seen and treated between the years 1950 and 1954. Patients with intraepithelial cancer are not included in this series. One hundred and eighty-nine patients (87.9 per cent) have been followed through the year 1959; 26 patients (12.1 per cent) not located are presumed dead of the disease. These patients are now eligible for a five year survival study, and the purpose of this paper is the presentation of these data.

Analysis of Series

In this series 123 patients (57.2 per cent) were Negro and 92 (42.7 per cent) were white. The reproductive history of the patients revealed that 159 (73.9 per cent) had borne children and 23 (10.7 per cent) were nulliparous. In 33 (15.4 per cent) the parity was not indicated. The ages of the patients ranged from 19 years to 79 years; 150 (69.6 per cent) were more than 40 years of age (table 1).

Forty-eight patients had been subjected to previous pelvic surgery. Sixteen of the operations were sterilizing procedures of which 13 were subtotal hysterectomies. All but one of these 16 operations occurred more than three years prior to the diagnosis of carcinoma. This is a striking illustration of the need for total hysterectomy in the prophylaxis of cancer of the uterine cervix.

Vaginal bleeding, the most frequent initial complaint, occurred in 177 (82.3 per cent) of the patients. There were 23 patients (10.6 per cent) who complained of pain associated with bleeding. In 22 (10.2 per cent) the presenting symptom was leukorrhea. Symptoms were not recorded in 15 patients (6.9 per cent).

Arbitrarily, a disregard of symptoms of more than one month's duration was considered a delay in diagnosis. Suspicious symptoms had been present for more than one month in 178 patients (82.7 per cent). For 20 patients the duration of symptoms was not recorded (table 2).

The extent of the disease was classified in accordance with the international classification. The 215 patients were divided as follows: 47 (21.8 per cent) in Stage I; 68 (31.6 per cent) in Stage II; 60 (27.9 per cent) in Stage III, and 31 (14.4 per cent) in Stage IV. In 9 patients (4.1 per cent) the extent of the disease was not described. A total of 73.9 per cent of the patients had advanced lesions at the time of diagnosis. The diagnosis in all patients was established microscopically from cervical biopsy specimens.

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Read before the Florida Medical Association, Eighty-Sixth Annual Meeting, Jacksonville, April 9, 1960.

Table 1. — Age of Patients Studied

Age	Number of Patients
19	1
20-29	12
30-39	43
40-49	47
50-59	48
60-69	45
70-79	10

Table 2. — Diagnostic Delay

Duration of Symptoms	Number of Patients
1 month	17
2 months	16
3 months	23
3 to 6 months	50
6 months or longer	89
No date recorded	20

Table 3. — Five Year Salvage

Stage	Patients	Living	Salvage in Per Cent
I	47	20	42.5
II	68	16	23.5
III	60	2	3.4
IV	31	1	3.3
Unknown	9	0	0.0

During the period of this study 211 patients were treated with a combination of radium and deep x-ray therapy. In the majority of patients, radium was administered first. With employment of an Ernst applicator, a total of 5,000 mg. hours was given in a single application. This consisted of 2,500 mg. hours of intracervical radium and 2,500 mg. hours of contracervical radium. This therapy was followed in six weeks by deep x-ray therapy. Over a period of 25 to 35 days a total of 8,000 r to 10,000 r was given through two anterior and two posterior ports. Four patients were treated by radical hysterectomy, bilateral salpingo-oophorectomy and pelvic lymphadenectomy. Of the patients treated surgically, one patient is living and well eight years after the operation, and three patients are living and well six years after the operation.

In this series, complications of treatment were frequent. Of the 215 patients treated, 57 (26.5 per cent) had serious complications that were attributable to the therapy. These complications included: 18 (8.3 per cent) vesicovaginal fistulas; 12 (5.5 per cent) rectovaginal fistulas; 16 (7.4 per cent) ureteral obstruction, and 11 (5.1 per cent) rectal strictures.

To date 150 patients (69.7 per cent) have expired. Twenty-six (12.1 per cent) not located are presumed dead of the disease. Only 39 (18.1 per cent) are living and well five years or longer after treatment. Table 3 shows the salvage in 215 patients who were followed five years or longer.

Discussion

From 1950 through 1954, 215 patients were treated for cervical carcinoma. The histories of these patients differ little from those of similar groups which have been treated and reported by other clinics. The age of the patients, the marital status, the parity and the symptoms are similar. The five year salvage, however, is far below the standard accepted today. There are several factors which seem important in the explanation of this different survival rate.

A delay in treatment and the large number of advanced lesions contributed greatly to these poor results. In 82.7 per cent of the patients, there was a significant delay in the institution of treatment. In 73.9 per cent of the patients, the disease had extended beyond the cervix.

A second serious factor contributing to the low five year salvage was the apparent lack of planning and administration of therapy for the individual patient. The dosage of 5,000 mg. hours of radium was inadequate. Most therapists today recommend a minimum of 6,000 to 7,000 mg. hours of radium applied intracervically, contracervically and colpostatically, varying of course with the lesion and the method employed. The total dosage of deep x-ray therapy in this series was between 8,000 r and 10,000 r. The accepted dose today is between 12,000 r and 16,000 r over four to six ports. The fact that the therapy was inadequate under present day standards is strikingly illustrated by the salvage rate of only 42.5 per cent in Stage I lesions. Most clinics report a five year salvage of 65 per cent to 75 per cent in invasive lesions confined to the cervix.

It is also unquestionable that a lack of careful follow-up is a big factor in causing the study to indicate these poor results. Follow-up is mandatory if the treatment of this disease is to be properly evaluated, for without knowing the results of one's therapy, one can never ascertain the success or failure of various therapeutic techniques. In this series it is known that only 59 (27.4 per cent) of the patients expired as a direct result of the disease, and that 14 (6.5 per cent) died of other known causes. Of the remaining 129 patients (60 per cent), 26 (12.1 per cent) could not be located, and 103 (47.9 per cent) died of unknown causes. These figures document the inadequacy of follow-up. Proper instruction

of personnel in the recording of data and adequate social service contacts can correct this. Facilities for terminal care and postmortem study would add greatly to the ability better to evaluate therapy.

The substandard salvage rate indicated by this report substantiates the contention that a well organized clinic is essential for the proper treatment of cervical carcinoma. For this reason the Gynecological Tumor Clinic was organized in 1957. The Clinic is supervised at all times by a qualified gynecologist, who, in conjunction with the resident staff, the pathologist, the radiologist and the social service worker, supervises the diagnosis, treatment and follow-up care of these patients. By such combined effort we hope to attain therapeutic success which will compare favorably with that of other accredited tumor clinics.

Summary

From 1950 through 1954, 215 patients were treated for cervical carcinoma. The five year follow-up rate was 87.9 per cent.

The age, marital status and parity of these patients were similar to those of other series. There was no significant difference in race; 57.2 per cent were Negro and 42.7 per cent were white.

The proportion of advanced cases was high; 73.9 per cent of the patients had lesions which extended beyond the cervix. A delay in diagnosis occurred in 82.7 per cent of the patients.

Except for four patients who were treated surgically, therapy consisted entirely of irradiation.

The five year uncorrected survival rates were: 42.5 per cent in Stage I; 23.5 per cent in Stage II; 3.4 per cent in Stage III, and 3.3 per cent in Stage IV. The over-all salvage was 18.1 per cent.

The five year salvage does not compare favorably with that of other clinics. This difference is attributed to the large number of advanced cases, inadequate therapy, and a lack of careful follow-up.

Duval Medical Center (Dr. Cannon).
2033 Riverside Avenue (Drs. Duckett and Williams).

Discussion

Dr. Harold E. Davis, Miami: This report reminds us that a solution to the management of carcinoma of the cervix requires continued study and improvement in methods of treatment and close cooperation and understanding between gynecologist and radiotherapist. It is worth while to note that only 21.8 per cent of the patients in this series were seen initially with Stage I of the disease. In several large therapy centers, the incidence of Stage I has been given as about 70 per cent.

I agree that where hysterectomy is indicated, it should always be total, if at all possible, and thereby avoid the incidence of carcinoma of the stump and the attending difficulties of later therapy.

It is difficult for a radiologist to analyze radiation effects or failures without accurate knowledge of the dose distribution and fractionization of local therapy or of the quantity, quality and fractionization of external therapy. Local radiation dosages in this series of cases are considerably lower than radiologists consider as adequate. This has been recognized by Drs. Cannon, Duckett and Williams in the summary.

The quality of irradiation is not accurately defined as we consider the amount of absorbed irradiation (rads) as more definite especially with reference to point B. This x-ray therapy was probably produced by conventional x-ray facilities and the quantities delivered to the primary tumor and lymph node areas were probably the maximum which may be obtained from conventional x-ray sources.

Modern facilities may deliver an increased dose to the lateral pelvic lymph nodes. Control of this lesion depends almost entirely on control of lymph node extension. Meigs has stated that "node dissection is, at best, a crude dissection of pelvic nodes. Often the nodes are so small that they cannot be seen and often nodes in an easily dissected area are left behind." We believe that external cobalt 60 irradiation may be used to deliver 5,000 to 5,500 rads in a period of four weeks to the iliac, ureteral and obturator node areas or the region of point B. A percentage of pelvic lymph nodes is controlled by external irradiation; otherwise, there would be only a small salvage of Stage II and negligible salvage of Stage III, particularly with therapy with conventional x-ray.

Drs. Cannon, Duckett and Williams in their discussion have recognized the inadequacy of both external and local irradiation therapy in the years under discussion.

As to the complications, there was undoubtedly a high percentage of infection, thereby increasing the incidence of complications and especially fistula formation.

We are particularly conscious of the timing and quantity of irradiation delivered to point B and the lymph node area in the lateral pelvis. The relatively high incidence of various fistulas can be reduced, we believe, by adequate external irradiation prior to local or intracavity therapy. It has been stated that 60 per cent of all cases show paracervical extension, and even 50 per cent involvement is significant.

We believe that an improved approach may be obtained by closer cooperation between gynecologist and radiotherapist whereby there may be better understanding of external irradiation in terms of rads delivered to the lymph node area.

Thank you for the privilege of discussing this paper, and may I congratulate and encourage the authors in their efforts to improve salvage rates in carcinoma of the cervix?

Dr. Richard W. McDowell, Jacksonville: The report of Drs. Cannon, Duckett and Williams verifies the necessity for review of a department's activities on a periodic basis in order to evaluate its accomplishments. I am sure the attending staff were aware of the poor results, but incorrectly attributed them to the high percentage of late cases seen. A similar report by Dr. Schmitz, who reviewed the activity of eight clinics staffed by board diplomates in a large metropolitan hospital, showed a similar over-all five year salvage rate of 17.4 per cent, while the tumor clinic in the same institution under proper direction had far better results of 44.4 per cent.

A 42.5 per cent five year salvage rate in Stage I cases shows, as stated by Dr. Cannon, a lack of individual evaluation of each patient and a blind following of a standard form of treatment set up as a guide for treatment. More direct supervision and education in the principles of radiation given the resident staff by the attending staff should improve these results.

Total urinary tract complications of 21.2 per cent are far above most reports of a 2 to 8 per cent incidence. This difference can be due to single dose application of radium without attention to elimination of hot spots and to proper packing away of the bladder and rectum. X-ray confirmation of proper positioning of the radium application is a valuable adjunct to its use. Many of the urinary tract complications might have been avoided in late cases by the use of x-ray irradiation prior to radium. Again, closer supervision and check out of the resident's technique of radium application by the attending staff would serve to lower urinary tract sequelae.

The greatest possibility of improving results would be earlier diagnosis. A determined effort to rule out possible cervical carcinoma in all routine gynecological outpatients and inpatients, and in all female patients on medical and surgical services by the routine use of cytology smears and cervical biopsy should be made.

Lack of unified direction and supervision of treatment was unfortunate. This was due to an inadequate number of residents, residents of varied experience, and an all volunteer attending staff who served only three months service at a time in an institution with no private obstetrics and gynecology service. Since July 1956 the residency has had three year approval giving a smoother continuity of resident training and experience. The number of residents has increased from two to four, allowing more time for clinical investigation and reflection of work done. The number of attending staff has increased from 16 to 26, allowing the formation of the Gynecological Tumor Clinic with interested and qualified physicians assigned to it. I therefore am confident that the next report on carcinoma of the cervix at Duval Medical Center will show marked improvement.

The Allergy Investigation in a Subtropical Zone

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At the very beginning I should like to avoid any possible confusion that this title may occasion. It is not meant to imply that an allergy investigation in this part of the world is a different procedure, but rather that the geographic conditions prevailing here create more obscure, varied and complicated problems for the investigator.

Given a patient in whom other disease is found nonexistent or concomitant medical problems are recognized and treated, and in whom the signs and symptoms point to an allergic etiology, the investigation must begin in the usual manner with a comprehensive history. I would suspect that native white Nassauvians, like native South Floridians, comprise only about 20 per cent of our respective populations, so that the great majority of our patients come from geographically distant places.[1] Two or more separate etiological histories are therefore required since we become immediately concerned with two or more different atmospheric, botanical and environmental relationships.

This approach to history taking is of particular importance with pollen-sensitive persons. The patient who comes from an area of well defined pollen seasons can supply a history indicative of tree, grass or weed sensitivity that can be most helpful, and most important, considering the obscure pollen problems in our area with the general lack of sharp and reliable seasonal incidence. For example, a June-July history in the Eastern States or a June-July-August history in England, where I had some experience with American military personnel and British civilians during World War II, certainly suggests a grass sensitivity. This same patient may have symptoms from February to November from Bermuda grass and practically perennial symptoms from Johnson grass in our area.[2] There are, of course, other factors involved, such as the relatively marked antigenicity of grass pollen in England and the lesser quantity of grass pollen in our area.

Pollen

The pollen problem continues, after my 23 years in Miami, to be a changing and puzzling picture. The basic requirement for pollenosis, according to Thommen's Postulates, is a pollen that is antigenic, airborne and present in adequate quantity. This was the basis for a combined field, air and clinical survey begun many years ago, and still continuing, in association with Lillian Fly of the Botany Department of the University of Miami.[3-5] She studied over 200 pollens which were considered with the following points in mind:

1. Botanical and common names
2. Project number for blind studies

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3. Growth characteristics (fern, bush, sedge, weed, grass, tree)
4. Distribution in relation to Greater Miami
5. Species reported allergenic in other parts of the United States
6. Genus reported allergenic in other parts of the United States.
7. Family reported allergenic in other parts of the United States
8. Previously reported allergenic in the tropics
9. Type of allergy reported
10. Pollinating periods

From this group of 200 pollens, 50 were selected according to the Statistical Tukey Test, which utilizes ragweed as a control to predict probable allergenic activity. We have worked with these extracts and while final conclusions have not been drawn, certain principles have been recognized:

1. Pollen allergy is not a common problem in in our area.
2. Most plants produce little pollen for a variety of reasons including poor growth conditions in the soil, expenditure of plant energy toward growth rather than reproduction, and failure of pollen to achieve airborne status due to heavy humidity-laden air.
3. Many common plants produce pollen of low antigenicity, such as Australian pine[6] and melaleuca.
4. Many plants produce pollen that is not airborne, such as oleander and hibiscus.
5. Since the prevailing breeze is off the ocean 80 per cent of the time, pollen is blown inland. This is protective for beach areas but not the newer residential areas north and south of Miami.
6. Most cases of pollenosis result from sensitivity to:
   a. Ragweed
   b. Bermuda grass
   c. Johnson grass
7. Undoubtedly some cases of pollenosis are not solved due to uncommon and therefore unrecognized sensitivity to:
   a. Australian pine
   b. Melaleuca
   c. Baccharis (Saltbush)

TABLE 1.—POLLINATING PERIODS

PLANT NAMES G—Grass W—Weed T—Tree B—Bush	GROWTH CHARACTERISTICS	SPECIES ALLERGENIC IN OTHER PARTS OF U.S.	GENUS ALLERGENIC IN OTHER PARTS OF U.S.	FAMILY ALLERGENIC IN OTHER PARTS OF U.S.	REPORTED ALLERGENIC IN TROPICS	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.
Bermuda grass	G	X	X	X	X												
Jahnsan grass	G				X												
Ragweed	W	X	X	X	X												
Australian pine	T				X												
Melaleuca	T																
Baccharis	B																
Live oak	T	X	X	X													
Willow	T	X	X	X													
Trema	T																
Iresine	W			X													
Red Mangrove	T																

d. Live oak
e. Florida willow
f. Trema
g. Iresine
h. Red mangrove
i. Others on rare occasions

Most of these are so uncommon that an etiological diagnosis requires confirmation with positive conjunctival and passive transfer tests with negative controls.

8. Ragweed, which was a negligible offender years ago, seems to be causing more cases each year, beginning six or seven years ago coincidentally with the marked peripheral expansion of Greater Miami.
9. Ragweed has a long pollinating season, from May to November.
10. Here again it is demonstrated that ragweed invasion readily occurs following community growth. An opportunity is presented for local health authorities to utilize recognized means of eradication. If Miami can become so affected, so might Nassau.

There remains one more problem in the study of pollenosis in this area. Since our population comes from other parts of the country, people tend to return to their former homes during vacations, generally from spring to fall. Good allergy treatment, therefore, requires consideration of their northern sensitivities in the hyposensitization program.

Molds

Mold sensitivity is an accepted problem in allergy, with varying degrees of enthusiasm, throughout the world. I believe it is true, as one would expect, that molds and fungi are of considerable importance as a respiratory allergen in our subtropical climate. They constitute a perennial problem, although there are unpredictable and irregular concentrations of all the molds by slide and plate studies. Although there are probably other unrecognized molds that are capable of inducing sensitization, which indicates the need for continued study, routine testing is performed for sensitivity to the following molds:

1. Alternaria
2. Hormodendron
3. Aspergillus
4. Penicillium
5. Phoma
6. Helminthosporium
7. Corn smut
8. Johnson grass smut
9. Cephalosporium
10. Rhizopus
11. Mucor
12. Botrytis
13. Fusarium
14. Trichoderma
15. Yeast
16. Puccinia
17. Fuligo
18. Monilia

Positive reactions are commonly demonstrated to Alternaria, Hormodendron, Aspergillus and Penicillium, but local emphasis is needed on the other molds listed, with particular emphasis and reference to Helminthosporium, Phoma, Johnson grass smut and Fusarium. The wood spores, Puccinia and Fuligo, have little clinical significance. The same might be said for the large numbers of streptomyces found on plates and slides,[7] if our clinical data are like those found elsewhere. It is of practical importance to note that previously controlled patients can have a recurrence of symptoms from exposure to these molds when moving to or visiting our area.

Inhalants

Household inhalant sensitivities would seem to offer little local differences, but there are certain significant considerations concerning this problem. A common situation exists of rooms and apartments being closed during the summer. These unoccupied dwellings allow for the accumulation and concentration of antigens, including exterminating materials, which are then explosively presented to the first occupant the following winter. The common practice of low cost construction with concrete floors and the effort to give a plush walking surface lead to the widespread use of animal felt padding and exposure to the allergens contained therein. There are infrequent, sudden and marked cold spells during the winter resulting in exposure to stored blankets, warm clothes, oil stoves, and gas and electric heaters. Economy-minded tourists seek housing in which there is overcrowding of people, clothing and possessions which further complicates the exposure index. The simple procedure of packing or unpacking constitutes a hazard.

We see a migratory type of population, even among legal residents, who have no knowledge of previous occupants in their homes, and who give

no thought to avoidance principles. The acquired tolerance to allergens, including bacteria, in their permanent environment is no longer protective. For all these reasons allergic persons make poor travelers. More emphasis concerning avoidance and the need for continued specific therapy might minimize these problems.

Foods

Food allergy presents a comparable problem. It is a fairly common observation that many patients soon have trouble when they disregard dietary restrictions. It is difficult to explain, but newcomers act as if coming to our area frees them from all the chains imposed by their immune mechanisms at home. Not the least of our problems is the tendency of vacationers to overeat at the evening meal.

While the incidence and offenders of food allergy are probably the same in the subtropics as elsewhere, the temptation to overindulge in citrus fruits, chocolate, fish, shellfish, nuts, alcoholic beverages and the like is great. Since so much of our food comes from distant places, the problem of preservatives, additives and coloring materials in foods must be considered. It may be surprising information, but sensitivity by ingestion to tropical foods such as mango, papaya and avocado is extremely rare.

Of course, investigation of food sensitivity is the same here as elsewhere with the personal preference of the investigator determining the technique. The incidence is directly proportional to the index of suspicion and perseverance of the investigator. The combination of scratch or puncture tests with elimination diets offers the best approach, the extracts being fresh and the ingested foods being in as raw a state as possible. It is worthy of emphasis that it is not an admission of failure or negligence when it becomes necessary to retrace the steps of an elimination diet.

Bacteria

Bacteria and viruses, consisting of foreign proteins and therefore potentially antigenic, whether pathogenic or nonpathogenic, always reside in the body awaiting a stressful situation to become active. That bacterial allergy occurs as a true entity is no longer questioned since there is adequate clinical and experimental proof. Our area shares with other areas the difficulty in diagnosis because of the inadequacy of testing materials and the scores of bacterial strains in the body. Until such time as methods are found to detect specific offenders, our efforts will be empirical and the results from vaccine and/or antibiotic maintenance therapy will be variable and discouraging, but well worth the effort. The incidence of respiratory infection is high here with new strains of offenders being constantly introduced by visitors. The recently available adenovirus-influenza vaccine appears to be of some prophylactic value, and logically used in patients with allergy of the respiratory tract who are not egg-sensitive.

Insects

Consideration of insect emanations as a cause of respiratory allergy has achieved popularity in our area as well as elsewhere. Our climate is certainly conducive to this problem. Much original work in this field is now in progress at the University of Miami, the results of which should be most rewarding.[8]

We are presently testing, with caution, for sensitivity to the following insects:

1. Moth
2. Cricket
3. Beetle
4. House fly
5. Ant pupa
6. Daphnia (water flea)
7. Mixed insects
8. Mosquito
9. Sand fly

The mixed insect, beetle, moth and cricket extracts have, on occasion, given strong positive reactions. Therapy has been attempted in only a few patients, with the results difficult to interpret since the duration of treatment has not been long enough and patients with pure insect-induced respiratory allergy have not been recognized as yet. A major difficulty is obtaining pure material for extraction and producing a nonirritating extract.

Dermatological Factors

We share with others the common dermatological problems of allergic etiology, but outdoor living, prolonged periods of warmth and sunshine, and perennial foliage are conducive to certain dermatological lesions indigenous to this area. Periodic invasion by jellyfish and men-of-war causes severe local, and sometimes general, chemo-allergic lesions and reaction in swimmers. The use of suntan cremes and oils commonly produces contact dermatitis. Drug-induced photosensitivity reactions as well as the photosensitivity with

Berloques hyperpigmentation dermatitis from perfumes and lime peel oil are common. The skins of mango and other citrus fruits are also common offenders. The red ant, mosquito and sand flea urticarial reactions are troublesome to golfers, beachites and even stay-at-homes. While poison ivy is not found in this area, the same lesions result from contact with poison oak and sumac. Insecticides used on lawns for chinch bugs and other invaders produce a most irritating allergic eczematoid dermatitis. The toxic scorpion reactions and hypersensitivity reactions from stinging insects may cause severe local and dangerous constitutional reactions of anaphylactic nature. True solar allergic reactions are seen, but fortunately are rare. Secondary effects of sunlight are, as mentioned, a common complicating factor. In general, these dermatological conditions are all aggravated by hot and humid weather, which must be made an important consideration when determining therapy.

Psychogenic Factors

No discussion of an allergic investigation would be complete without considering psychogenic factors. I see no conflict between this statement and the accepted principles of the antigen-antibody reaction in immunology. Perhaps the future will reveal that the same chemical agent, for example serotonin, is the end product or agent responsible for the tension state and, with histamine-like substance, acetylcholine, et cetera, for the physiological result of an antigen-antibody union. However it is said or explained, now or in the future, it is obvious that allergic persons may have a reproduction of symptoms as a result of a psychological insult. The nature of our communities in which newcomers appear following failures in marriage, health, business and social activities in their home communities, in addition to the vacation type economy and atmosphere of our area, lends itself to psychological stress.[9] It seems reasonable that permitting the patient to ventilate his hostilities and resentments along with guidance and the use of ataraxic drugs, some of which are antihistamines, can be a useful part of an investigation. The relief of anxiety and fear is essential throughout history taking, testing and treatment.

Atmospheric Factors

It is commonly considered that atmospheric conditions in the subtropical zone are beneficial to the asthmatic. This assumption is possibly true on a comparative basis with weather conditions in some other places, but it should be made general knowledge that we also have dramatic variations in temperature, wind velocity, rainfall, and barometric pressure which can be troublesome to our patients. Adverse reactions occur, irrespective of specific sensitivities, which could be called "epidemic respiratory allergy."[10]

Conclusion

Finally, it should be stressed that no amount of sympathomimetics, antihistamines, or corticosteroids, no matter how great the patient acceptance, or how carefully they are used, replaces specific diagnosis whenever or wherever possible, even in the subtropics. On the other hand, great familiarity is needed with these and other drugs, since it is not usual that a patient can be given complete symptomatic control without supplementary medications, preferably withheld until after completion of the allergy survey.

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Internal Carotid Artery Occlusion

Surgical Management with Regional Hypothermia

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Occlusion of the internal and common carotid vessels has long been recognized as one of the causes of cerebral ischemia and dysfunction. The many publications in medical literature, both old[1-4] and recent,[5-9] emphasize the importance of neck vessel occlusion as a cause of cerebral dysfunction. Not too many years ago the diagnosis of carotid artery occlusion was made primarily at autopsy and rarely ante-mortem. The rapid advances in vascular surgery in the past decade and the interest which these advances have generated in angiography have made angiographic procedures commonplace in most modern medical institutions. Today because of the widespread use of angiography the diagnosis of cerebral ischemia due to neck vessel occlusion can be made almost as soon as symptoms develop. Cerebral angiography properly performed is one of the most useful diagnostic aids in the evaluation of organic brain disease.

The purpose of this paper is to present the method my associates and I employ in the management of those patients who have internal carotid artery occlusion and to emphasize the importance for early evaluation of all patients with symptoms suggesting organic brain disease. Diagnosis of internal carotid artery occlusion must be made before complete interruption of the hemispheric blood flow occurs if any remedial measures are to be effective.

Pathology

The site of arteriosclerotic occlusion of the internal carotid artery begins at or near the carotid bulb. The atheromata completely encircle the vessel lumen and extend up both the internal and external carotid vessels and characteristically extend no more than 3 cm. cephalad to the bifurcation. Once thrombosis has occurred, organized clots can extend well up into the skull, but as a rule the atheromatous plaques, which are the underlying cause of the occlusive disease, usually do not extend beyond the area described. The fact that the disease process is limited to the immediate vicinity of the carotid bifurcation makes surgical correction not only possible but ofttimes easily accomplished.

As in atheromata elsewhere in the body, the intimal and subintimal layers of the artery are destroyed by lipid deposits with resulting inflammation and often calcification. The final episode in complete occlusion is thrombosis of the narrowed vessel lumen, and when such an event occurs, blood flow beyond this site is completely and permanently interrupted (fig. 2).

Symptoms

The neurologic manifestations of internal carotid artery occlusion are varied, depending to a large measure on whether the occlusion is partial or complete with the onset of symptoms. If, however, one traces the course of the disease from first symptoms, a rather definite pattern can be observed. Of the 384 cases reviewed by Luessenhop,[10] in only 107 were the initial symptoms of such a nature as to be interpreted as complete occlusion of the internal carotid artery. In other words, in 277 of the 384 cases reviewed the symptoms were intermittent or gradual in onset and presumably represented partial arterial occlusion at the time symptoms began. In many of the patients falling into this group of partial internal carotid artery occlusion the condition frequently is diagnosed as a "mild stroke" or a "small stroke" from which they may completely recover. Recurrent episodes of motor weakness, aphasia, or sensory loss should alert the attending physician to the possiblity of neck vessel occlusion. Intermittent or episodic neurologic manifestations demand immediate investigations. Today's clinician should no longer be satisfied with a diagnosis of "stroke."

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Other patients with carotid occlusion may have a gradual onset of symptoms, or perhaps a better description would be a permanent loss of cerebral function by small increments, by gradual extension of the ischemia to other areas of the brain.

It is not my wish to leave the impression that all strokes are caused by internal carotid artery occlusion, but evidence is mounting that a considerable number of such cases can and have been overlooked if one is content to rest with the diagnosis of "stroke."

Diagnosis

The diagnosis of occlusive disease of the internal carotid artery may be suspected clinically, but can only be made with certainty by carotid angiography. The auscultatory finding of a bruit over the carotid bulb is not diagnostic although a bruit would necessarily raise the index of suspicion. Ophthalmodynamometer pressures have been proposed as a diagnostic method. In two of the cases in the series here presented pressures were reported as unusually low. This procedure may prove to be extremely valuable, particularly in the preoperative and postoperative studies as an additional diagnostic aid.

The usual neurologic work-up which includes chest and skull x-rays plus spinal tap is routinely performed. Carotid angiography by way of the percutaneous route with the use of 10 cc. of 50 per cent Hypaque is our method of choice. Both lateral and frontal views are obtained with separate injections of each carotid system. Vertebral angiography is not routinely used.

Surgical Management

Once the diagnosis of occlusive disease of the internal carotid artery has been established, the patient is readied for an operation at the earliest practical time. Under general anesthesia the common carotid and internal and external carotid arteries are exposed through an incision anterior to the sternomastoid muscle. Division of the facial vein allows for better exposure. The first two branches of the external carotid artery, the superior thyroid and ascending pharyngeal, are divided for better mobilization. Occlusive tapes are placed proximal and distal to the carotid bulb. At this point the surgeon's finger can palpate the carotid bulb and the extent of the atheromatous process extending into the internal and external carotid vessels. Just prior to occluding the vessels an 18 gauge needle is thrust into the internal carotid artery beyond the occluding tapes. Blood flow through the bulb is interrupted by snugging the tapes or by use of occlusive vascular forceps. Immediately an intra-arterial infusion of cold, heparinized blood under pressure is begun by the anesthetist. This blood is at blood refrigerator temperature and is pumped vigorously through the internal carotid vessel. A total of 500 cc. of blood is forced through the cerebral hemisphere in approximately five minutes, roughly 100 cc. per minute.

Operation on the artery is begun as soon as the infusion is begun. Endarterectomy is performed through an incision beginning on the common carotid artery and extending up the internal carotid artery. When the infusion is complete, the needle is removed and the operation continues. After development of the proper plane in the region of the carotid bulb, endarterectomy is carried out with removal of all atheromatous plaques and loose intima in the carotid bulb and internal carotid artery. The atheromatous plaques in the external carotid artery are removed only for a sufficient distance up the external artery to allow a good flow of blood past the carotid bifurcation. The arteriotomy site is washed with saline and rapidly closed using 5/0 arterial silk sutures. The tapes are removed from the external, common and internal carotid arteries in that order. An occasional suture may be needed to reinforce the suture line. The total time of occlusion averages 12 to 15 minutes. This step completes the operative procedure. The incision is then closed in layers. Heparin is only used locally as a weak solution to wash the operative area. Systemic anticoagulants have not been used.

Analysis of Series

Experience gained in the management of 10 cases of internal carotid artery occlusion (table 1) is the basis of this report. It is obvious that statistically significant conclusions cannot be postulated on such a modest series; however, the results obtained in those cases of partial occlusion of the internal carotid artery are so encouraging that I am confident our management is on a sound logical basis. In the first three cases in this series angiograms demonstrated complete occlusion of the internal carotid artery. Endarterectomy was performed in all three cases, and in none were we able to re-establish hemispheric circulation despite the fact that in two cases there was back flow from the internal carotid artery at

Table 1. — Analysis of Ten Cases of Internal Carotid Artery Occlusion Managed Surgically

Case	Age	Sex	Symptoms	Angiography	Neurologic Deficit Preoperative	Neurologic Deficit Postoperative	Results of Surgical Therapy	Present Status
1* 5/13/58	51	M	Aphasia, memory loss, motor weakness, right, progressed to right hemiplegia.	Complete occlusion of left internal carotid artery	Hemiparesis, right, aphasia	Same	Unimproved	Speech improved, ambulatory, lost job as supermarket manager
2* 5/27/58	45	M	Recurrent episodes of confusion, slurred speech, progressed to hemiparesis	Complete occlusion of left internal carotid artery	Hemiparesis, right, loss of memory, slurred speech, aphasia	Same, improved with time	Unimproved	Working part time, good use right arm and leg, emotionally unstable, irritable
3* 7/9/58	45	M	Awakened with severe headache and left hemiparesis which cleared completely. Three days later complete hemiparesis, left	Complete occlusion of right internal carotid artery (fig. 1)	Hemiparesis, left	Same	Unimproved	Ambulatory, no function left arm, lost job, unable to work
4* 4/6/59	65	F	Recurrent anesthesia of left hand and tongue, mental confusion, impaired vision right eye, progressed to blindness	Incomplete occlusion of right internal carotid artery, good filling of vessels beyond site of occlusion	Loss of vision right eye	Loss of vision right eye, no recurrence of mental confusion or anesthesia	Very good	Mentally clear, visual loss permanent, otherwise well
5* 5/2/59	54	M	Recurrent headache, confusion, hallucinations, recurrent right hemiparesis, cleared, progressed to hemiplegia	Incomplete occlusion of left internal carotid, both anterior cerebral arteries filled from left carotid system	Right hemiplegia, left carotid pressure produced unconsciousness	Hemiparesis, right, much improved	Very good	Ambulatory, paresis right arm, working daily
6* 6/23/59	59	F	Headache, progressive right hemiplegia, slurred speech, mental confusion	Complete occlusion of left internal carotid artery	Hemiparesis, right	Same	Unimproved	Ambulatory, working part time, unable to write
7 11/6/59	60	M	Recurrent small strokes and loss of memory four years prior, two months prior left-sided weakness lasted one day, one week prior left hemiplegia lasted four hours	Incomplete occlusion of right internal carotid artery at its origin	Aphasia, slight, unable to read, blurred vision, cannot dial telephone, unable to add figures	None nine months postoperatively	Excellent	Returned to usual activities, working full time
8 1/12/60	78	M	Recurrent episodes of weakness right arm and leg; unable to write, an accountant prior to illness, memory loss	Incomplete occlusion internal carotid artery at its origin	Weakness right side, primarily in arm, unable to write, slight aphasia and slight memory loss	Very slight weakness of arm, writes well, no aphasia or memory loss	Excellent	Returned to usual activities
9 6/17/60	55	M	One week prior incoordination right hand, right leg dragging, lasted one hour, symptoms recurred, lasted one and a half hours, cleared	Incomplete occlusion of internal carotid artery, left.	None	None six weeks postoperatively	Excellent	No recurrence of symptoms, returned to usual activities
10 8/1/60	55	M	One week prior weakness in right leg, cleared; weakness, incoordination right arm, slurred speech, blurred vision left eye, recurrent	Incomplete occlusion of left internal carotid artery at its origin, lumen markedly narrowed	Unable to write, blurred vision left eye, weakness right hand, slight aphasia	None six weeks postoperatively	Excellent	No recurrence of symptoms, returned to usual activities, working full time

* Previously reported[16]



Fig. 1.—Case 3, 45 year old white man. Angiogram demonstrates complete occlusion of right internal carotid artery.

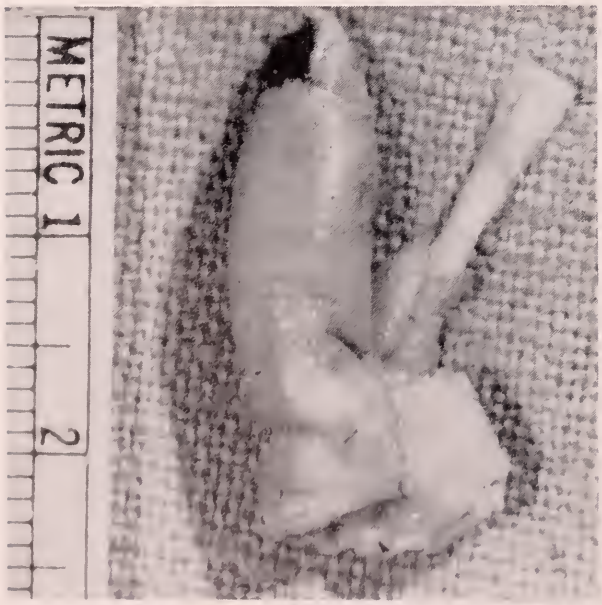


Fig. 2.—Specimen, case 3. The atheromatous cone has been removed intact from internal carotid artery and carotid bulb. Note fresh thrombus which formed at narrowed lumen. This patient not improved by operation.

the time of the operation. The third case (figs. 1 and 2) is most important in that complete occlusion occurred while the patient was in the hospital under observation for recurrent episodes of hemiparesis which had cleared after each episode. Suddenly almost complete left hemiplegia developed. Angiograms demonstrated complete block of the right internal carotid artery. He was operated on as an emergency approximately 18 hours following onset of these distressing symptoms. Endarterectomy was performed, and despite the fact that back flow was obtained from the internal carotid artery and vigorous pulsations could be felt beyond the arteriotomy site, effective cerebral blood flow was not established. Ischemic necrosis had already occurred in the area of the right internal carotid distribution. This patient was not benefited by surgical therapy. The specimen (fig. 2) removed at operation shows the atheromatous cone and the fresh intraluminal clot which was the final episode in producing hemispheric ischemia and necrosis in this patient.

Experience gained in treating these first few patients, however, provided us with extremely important information. The atheromatous plaques were found to be limited to the carotid bulb and to the adjacent areas. This finding in itself was encouraging.

None of the four patients (cases 1, 2, 3 and 6) in whom complete occlusion had occurred were improved by the surgical removal of the occlusive disease, and their subsequent course was essentially the same as would be expected under nonoperative management. Two of the four are gainfully employed although residual hemiparesis remains. The other two have improved, but also have residual hemiparesis.

In the remaining six cases incomplete occlusion of one or the other of the internal carotid arteries was demonstrated by angiography (figs. 3-12). All were operated upon with use of the techniques and methods described. In all patients with partial occlusion of the internal carotid artery, circulation was re-established and in none has early or late thrombosis occurred at the time of this writing.

Unfortunately, we were unable to obtain postoperative angiograms in all cases. Two postoperative angiograms were obtained in the four cases in which the internal carotid artery was completely occluded, and as was to be expected, no cerebral blood flow could be demonstrated through the internal carotid system. Three postoperative angiograms were obtained in the six cases of incomplete obstruction of the internal carotid artery (cases 8, 9, and 10). In all three of these cases the arteriotomy site shows a lumen of nor-



Fig. 3.—Case 4, 65 year old white female. Angiogram demonstrates incomplete occlusion of right internal carotid artery. Symptoms of recurrent episodes of anesthesia of left hand and tongue and mental confusion. Diminished vision in right eye progressed to total loss of vision in this eye. Following operation loss of vision of right eye permanent. No recurrence of other symptoms.

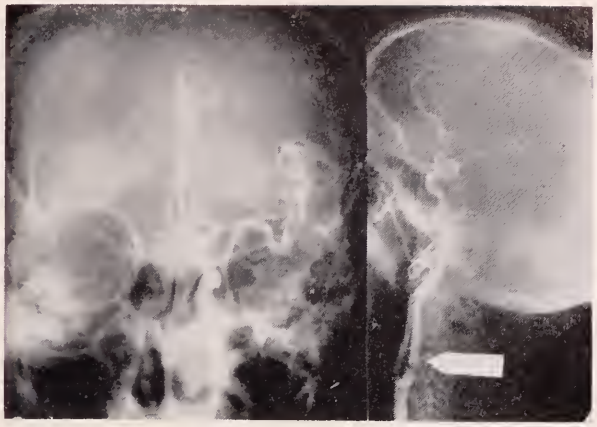


Fig. 4.—Case 5, 54 year old white man. Angiograms show narrowed internal carotid artery at its origin. Note filling of both anterior cerebral arteries from affected side. Compression of left internal carotid produced unconsciousness. Recurrent symptoms of hemiparesis had progressed to hemiplegia at time of operation. Improved since operation, but residual hemiparesis remains. Had complete occlusion occurred, survival, I believe, would not have been possible because of anomalous right cerebral artery filling from left carotid system.



Fig. 5.—Case 7, 60 year old white man. Angiograms demonstrate narrowed right internal carotid artery. Symptoms of recurrent hemiparesis, memory loss, unable to add figures or dial telephone. Nine months postoperatively no neurologic deficit.

mal size and good filling of the carotid system beyond the area of previous obstruction. In case 5 (fig. 4), because both anterior cerebral arteries filled from the affected side, if complete occlusion occurred, the patient in all probability would not survive. The clinical course of this patient leaves little doubt in my opinion that the internal carotid artery is patent and functioning normally. In case 4 (fig. 3) and case 7 (fig. 5) the clinical course of the patients following operation is such as to justify our statement that cerebral blood flow has been re-established in both instances. In case 4 the only neurologic deficit is loss of vision in the right eye. There has been no recurrence of mental confusion or recurrent episodes of anesthesia as described preoperatively. In case 7 the patient can read, write and add figures; he has had no recurrence of the episodes of hemiplegia.

Discussion

Internal carotid artery occlusion has been definitely established as one of the major causes of stroke.[11] The exact incidence cannot be determined at this time because of the lack of a sufficient number of authenticated cases. The victim of a stroke is a pitiful sight. The total amount of disability and suffering due to stroke is inestimable. Frequently the patients are active,



Fig. 6.—Case 8, 78 year old white man. A working accountant with symptoms of transient hemiplegia, memory loss which progressed to weakness and incoordination of right arm, unable to write. Angiograms show left internal carotid narrowing.

respected members of society, suddenly completely disabled and doomed to a lingering, often long, half life because of a stroke. They need not be in the retired or older age group. In this series two patients were 45 years of age, and the average age in the 10 cases was 57.6 years. Seven of the eight men were gainfully employed in responsible positions at the time their illness overtook them. The other man was retired but active (case 9).

For those patients in whom internal carotid artery occlusion is a cause of cerebral dysfunction

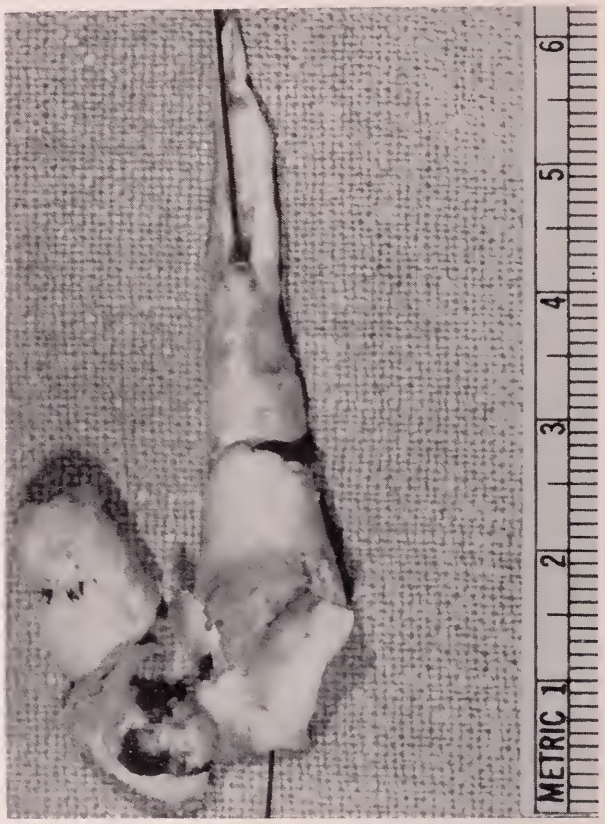


Fig. 7.—Specimen removed at operation (case 8). Corkscrew lumen can be seen on angiogram.

much can be accomplished provided an early diagnosis can be established. Recurrent neurologic signs or symptoms require immediate evaluation if we are to recognize this vascular problem before complete occlusion of the internal carotid system has occurred. In those cases reported here in which the diagnosis was made while the carotid artery was still partially occluded, the results have been outstanding. As a vascular surgeon I have had no more gratifying experience than to help restore to apparent normalcy a patient who appears, by all odds, to be doomed to the lingering half life of the stroke victim.

One of the major problems encountered at operation is protection of the brain from ischemic necrosis during the time the carotid vessels are completely occluded. It is true that temporary occlusion of one internal carotid artery can be safely carried out in many patients. As so well expressed by Bernatz[12] of the Mayo Clinic, however, those patients who will withstand such a procedure and those in whom irreversible damage will occur cannot be predicted with any degree of certainty. In at least one of the cases reported here (case 5), in which both anterior cerebral arteries filled from the affected side, compression of the left carotid bulb produced unconsciousness.



Fig. 8.—Postoperative angiogram (case 8). Normal internal carotid artery lumen. Recovery of function very gratifying. Writes well although without flourish and penmanship of which he was once proud. Residual weakness right upper arm. Memory loss has disappeared.

Undoubtedly there would have been further permanent loss of function and possibly death had the carotid vessel been clamped for a period of 12 to 15 minutes without some method of protecting the cerebral tissues. For this reason regional hypothermia has been selected as the method to protect the hemisphere during the time of complete arterial inflow occlusion. Regional hypothermia as an effective method of protecting brain tissue from ischemic necrosis during periods of diminished or interrupted cerebral blood flow has been established both experimentally and clinically.[13-15] In the method described in this paper, hemispheric blood flow through the carotid



Fig. 9.—Case 9, 55 year old white man. Angiograms show narrowed left internal carotid artery at its origin. Symptoms of recurrent hemiplegia and aphasia all cleared prior to operation.



Fig. 10.—Postoperative angiogram (case 9). Normal internal carotid artery lumen. Good cerebral filling. No recurrence of symptoms.



Fig. 11.—Case 10, 55 year old white man. Angiograms show extremely narrowed left internal carotid artery at its origin. Symptoms, recurrent weakness of right leg and arm, slurred speech, blurred vision, left eye, unable to write legibly.



Fig. 12.—Postoperative angiograms (case 10) show normal lumen of internal carotid artery. No recurrence of symptoms. No neurologic deficit, two months postoperatively.

system is completely interrupted and hemispheric perfusion carried out with heparinized blood at 4 C. or just above 4 C. It is anticipated that the temperature of the perfused brain tissue drops rapidly to safe levels. The degree of hypothermia appears to be adequate for the occlusion time used here. In none of the cases in this series was the neurologic deficit increased by the operation. The degree of temperature drop and the duration produced by this method are under investigation.

The operation of carotid endarterectomy would appear from our experience to carry a very respectable mortality and morbidity (table 2). All of the patients in this group were out of bed the day following the operation and discharged within five days to a week postoperatively.

Summary

Ten cases of internal carotid artery occlusion are reported and their surgical management is presented. A plea is made for early evaluation of any patient suspected of having organic brain disease. Two examples of delay in diagnosis (cases 3 and 5) progressed to permanent loss of



Fig. 13.—Note difference in lumen of internal carotid artery and excellent filling of cerebral vessels compared to preoperative angiograms (case 10, fig. 11).

Table 2. — Internal Carotid Artery Occlusion

	Number of Cases	Results of Surgery			Mortality and Morbidity (Surgical)
		Unimproved	Very Good	Excellent	
Complete Occlusion	4	4			0
Incomplete Occlusion	6		2	4	0
Total	10	4	2	4	0

function while under medical observation. In the other cases in which permanent damage occurred, a detailed history revealed that had medical aid been sought and had proper diagnostic methods been utilized at the onset of symptoms, considerable suffering and disability might have been avoided.

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Anxiety in Pregnancy

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MOUNT DORA

. . . In sorrow thou shalt bring forth children; . . . .
Genesis 3, 16

Today the expectant mother, going to her doctor for her antepartum visits, is examined as to her physical health, pelvic capacity, blood type and quantity and quality of blood. All too often the other side of the expectant mother is neglected; that is, the physician fails to examine the mother regarding her fears, apprehensions and anxieties associated with her pregnancy. These emotional stresses come from her social, physical and psychological changes. The physician fails to realize what is going on in the emotional makeup of the expectant mother. The mother often hides from her physician her fears and anxieties, which build up into a great storm within the individual. Because of this tendency of the expectant mother to hold these emotional disturbances within herself, the physician caring for the mother should be acutely aware of this tendency. The physician should make an effort to bring these fears and anxieties out and help the mother to overcome them, in order that she may approach her labor, delivery and postpartum period with a healthy, mature attitude towards this natural function of life.

The verse leading off this article is one that has persisted for too long a period and has taken an uppermost position in the mind of many mothers-to-be. It remains there and constantly nags them, creating fears, which often prevent them from having a happy experience at the time of the birth of the child that they long for and desire. It, therefore, becomes necessary that the physician be cognizant of these facts; he should not adopt a laissez faire attitude, nor should he neglect the care of his patient. The physician should work towards allaying his patient's anxieties by approaching the problems of pregnancy with care, consideration and understanding in order to help alleviate the anxieties.

Pregnancy Not an Illness

During pregnancy the entire individual is altered to some degree, not only her reproductive organs but many of the bodily functions. It becomes necessary during pregnancy to try not to give the expectant mother the feeling that this is a period of illness in her life. She is pregnant, but she is not ill and is not to be nurtured and cared for as a convalescent or ill person. It is important to stress this as a normal period in her life, in which the normal practices of good hygiene are necessary. Balanced diet, exercise and mental hygiene are important during this period and should be carried out as prior to the state of pregnancy.

It is, in fact, essential that the patient does not think pregnancy constitutes an illness. The attitude of illness is often created by the elaborate and strict rules laid down by the physician. All physicians should be extremely careful to discuss the hygiene with the patient and to let her know that it is hygiene she is taking and not treatment for an illness. The gestation period should be considered as the preparatory phase for the delivery and for the mother to prepare for the care of the infant after its delivery. The labor and delivery should be a happy moment in the woman's life, as it is the termination of a long wait and a long period of time in which anxieties can be built up. As Josh Billings recalled about waiting and the anxieties that can build up, "When I was a boy, I'd rather be licked twice than to be postponed once." This exemplifies the way many mothers-to-be feel—that this period of waiting is trying and allows anxieties to build up.

Apprehension

It is a period in which the mother becomes extremely apprehensive and often experiences a marked depression. In the majority of women this is not visible immediately. If the physician will scratch the surface a bit, he will be able to find these fears. The mothers are certainly willing and will freely discuss their problems, if probed a bit. The busy physician today often fails to rid the mothers of these fears and at the time of delivery he finds the mother is uncooperative,

fearful and difficult to handle. He wonders why. It is nothing more than at the extreme moments, when the mother should be calm and relaxed, she is not because of the emotional stress which she has been through during the antepartum period.

One of the causes of emotional disturbances is the lack of discussion of problems. How many doctors talk with expectant mothers about the details of the forthcoming confinement? This is a question that has been asked on many occasions. The patient feels that she is left in the dark, that she has to pick up tales, midwife tales from friends, good intentioned relatives and even perfect strangers, who, seeing a pregnant woman on the street, consider her open game for discussion of pregnancy. These women just love to tell about the difficult delivery they had, the excruciating pains they experienced, the lack of anesthesia or analgesics, and the cruelties which they suffered. The mother-to-be picks up the newspapers and reads similar articles. She reads "medical journals," such as the Reader's Digest, Woman's Home Companion and Ladies Home Journal. Articles appear regularly in these magazines regarding childbirth and its fearsome entities. With these sources to be combated, the physician must be cognizant of the mother's anxieties, of these fears and the long period in which she has to build them up, and he should take all possible means to alleviate them.

Allaying Anxiety

How this objective can be accomplished is the biggest problem. Certainly, the pregnant mother, coming into the physician's office for the first time, is full of anxieties. She has many questions which are time-consuming. The examination, which should be adequate and should include a complete medical history, takes time, but, in addition, the physician will find it worthy of his time to sit down and have a chat with the mother as to what she considers childbirth to be like, what past experiences she has had, what she expects to happen during the pregnancy, the antepartum period and certainly the labor. A discussion of the antepartum course, labor and delivery should be carried out at the first visit. Further discussions should follow after the mother-to-be has done some reading and has become accustomed to being pregnant and to the discussion of pregnancy. On subsequent visits she should be asked about anything which has come up regarding her pregnancy. She will ask questions as to the delivery, questions as to the antepartum and postpartum course.

During the eight or nine months in which she is carrying the child and is aware of her pregnancy, the mother lives, eats, drinks and sleeps pregnancy. Her friends discuss her pregnancy, it is the main topic discussed at the dinner table, it is discussed on the street, it is discussed all over. To the mother, especially the new mother, it is a new experience, something that is constantly with her; she cannot get away from it. Physically, her body is changing, enlarging; she has new feelings, new sensations coursing through her body, and she wonders what this is all about. If her physician does not give her the answers, she seeks them elsewhere, and usually the answers are either fabricated, or, at least, distorted a great deal and are detrimental to the mother.

What she is learning is the physician's responsibility, and the physician should guide the mother along reasonable lines, educating her as to what her pregnancy constitutes for her. In his talks with a pregnant patient, the physician should leave the door wide open for discussion. I have found it is a simple matter to inform the mother that I consider no question too small or too foolish to be asked—from what she eats to how she should dress and from how important exercise is even to the physician's ability to care for and deliver the patient. This information is important to her. On several occasions there have been brought out personality problems between the expectant mother and the physician, and by discussing these problems and bringing them out into the open, they have been alleviated and ironed out, so that by the time the mother is ready to commence labor and terminate her pregnancy, she is no longer apprehensive and fearful. All anxieties and antagonisms are gone. The problems have all been straightened out, and she does not have to enter her labor with these worries haunting her. She is free of mind and can concentrate on her labor, and it becomes a pleasant task for her.

The pregnant mother with her anxieties and fears often does not volunteer information concerning her moods and outlooks, self blame and self guilt. She often comments that these fears, depressed moods and anxieties are deserved and are not appropriate for treatment. Often the mother has fears of the child which is coming and with these she will have strong guilt feelings. She will feel that in early pregnancy she may not

have wanted the child. These guilt feelings build up and in turn build up anxieties, and she feels they are justly deserved. It is up to the physician to bring these out and to let the mother voice her feelings and then to assure her that it is not uncommon or unusual for the mother to feel as she does. He can give her assurance that these feelings will disappear and help her find a way to overcome these fears. The alleviation of the depression to which these fears and anxieties lead can be accomplished.

Summary

The goal of the obstetrician today is to deliver from the healthy mother a healthy child with as little trauma, physically and mentally, as is humanly possible. Childbearing should be an experience of satisfaction and joy, bringing to the mother a sensation of fulfillment and completeness, instead of dissatisfaction and horror. To accomplish the alleviation of pain and trauma, both mentally and physically, the physician utilizes many methods. He may use general anesthesia, local anesthesia, hypnosis or other methods. Regardless of which method is used, it is necessary to recognize the emotional status of the expectant mother and to adapt the mode of care and delivery to her individual constitutional capacity. This approach eliminates stereotyped management of delivery and antepartum care and necessitates individualized care, so that the mother may face the experience of labor with the greatest ease and as little anxiety as possible. This result can only be accomplished by the physician being constantly aware of the mother as an individual whose physical status is constantly being played upon by her psychological and social status. It is necessary that the physician be aware of these factors in order to care for the expectant mother as a whole and not care for her just physically and expect to have a satisfied, happy and emotionally sound mother following delivery of the child.

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The Role of Group Therapy in Psychiatry

A. Lester Stepner, M.D.*
Miami
and Bernard Tumarkin, M.D.**
Coral Gables

The individual when born is helpless and, as we know, must have support and care in order to survive. As Renee Spitz and others have shown, deprivation of essential mothering will lead to dire consequences in the development of the child's personality. This first relationship is in reality a group experience, namely, a diad. Through the experiences in this mother-child relationship, the child develops his capacities for humaneness. His environment is gradually expanded to include the father figure, siblings, peers and the whole gamut of human relationships, such as family, community, state, nation and the family of nations or the world. The experiences which the individual encounters from birth onwards are all involved in the process of socialization or acculturalization.

In order to exist we must become integrated into our society or else we will sooner or later come into conflict with it. A few moments' reflection will suffice for us to recognize that much of maladaptive behavior of the individual is in comparison to the empirically established norms of our culture.

Individual psychoanalysis has been the tool used in establishing the dynamics and structure of personality, in both health and disease. It has given us information about the development of the individual and understanding of the effects of the various forces of acculturalization from the viewpoint of the individual. Analytic group therapy is the most suitable method of resolving the conflicts and distortions which arise from maladaptations in the individual in the course of his experiences with the socialization process. Groups come into being when two or more individuals become involved in a relationship or transaction of any kind.

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History of Group Therapy

Better to understand the role of group therapy in our psychiatric armamentarium, it might be well to review briefly the history of this modality of therapy. In 1904, Dr. Joseph H. Pratt, a Boston internist, began a planned therapeutic approach to the emotional problems of patients suffering from pulmonary tuberculosis. His classes attempted to correct attitudes that impeded recovery from physical illnesses. He gave inspirational talks that would lift the patients out of their inertia, introspection and self pity. He antidated the techniques used by Alcoholics Anonymous in that he called upon them to describe their efforts, and the patients that made acceptable progress were moved up to the front benches and finally to the platform, where they were considered the star patients. This approach had the effect of encouraging other patients to improve, both by examples that had been set by the star patients and the striving for similar recognition in the group. It was so successful with tuberculosis patients that it was widely copied. It would seem from Dr. Pratt's first report (1906) that he initially regarded his group as a time-saving expedient; but within a few years, he came to recognize the potent psychological factors, and in subsequent reports he applied the technique to other conditions.

In 1937, R. W. Buck described a similar method with patients suffering from hypertension; M. N. Chappell and associates described their work in patients suffering from peptic ulcer. As early as 1920, Green found group discussions effective in the treatment of stutterers. He thought the group approach was of paramount importance, because he had found individual therapy ineffective. A stutterer suffers from a social neurosis; but in a group with the same problem, the nar-

cissistic barriers broke down, and the stutterer was able to overcome his symptoms and his anxiety.

In 1936, Louis Wender and Paul Schilder described techniques more suited to the therapeutic needs of the psychoneurotic patients than was the class method. Dr. Wender, working with mental patients in a private hospital, first utilized the class methods, but later added the small intimate group on an interview basis. He employed Freudian concepts and drew upon Freudian psychology for the content of material that was discussed in his groups. He visualized the human individual as a "group animal" seeking a satisfying niche in the social setting. While in Wender's practice the therapist occupied the center of the stage, it was still to a lesser degree than in Pratt's method.

Schilder introduced a more strictly psychoanalytic procedure in his work with the ward patients in the hospital. He worked with small groups of four to five patients and utilized the technique of free association. Having no set plan for the sessions, he introduced no special subject, nor were the patients encouraged to do so. His group interviews centered around the patients' personal problems and were discussed by all those who were present, including the therapist.

In the early 1940s, Benjamin I. Weininger of Washington, D. C., and Alexander Wolf, in New York, employed group therapy on psychoanalytic lines in private practice. We see then the progression of group therapy from the class method of Pratt and his followers through the aesthetic activation of Altshuler; through the psychodrama form of group technique that is employed by Moreno, the child play therapy of Slavson and others, to the analytic group therapy employed by Wolf and Foulkes. Today, we see group therapy used solely and combined with individual therapy.

Group Formation and Objectives

Formation of groups and the selection of their component members are often determined by the goal. For example, groups may be formed with therapeutic or research end points in mind. As mentioned, their formation may be motivated by an attempt to deal with specific problems, such as infidelity, obesity, social problems, or the education of parents with problem children. Intensive work is being done in groups composed solely of alcoholics, of drug addicts and of patients suffering from specific physical and neurological problems, such as multiple sclerosis. Group therapy has been employed to study personality of individuals engaged in specific activities, such as teachers and students.

Groups are classified as homogeneous or heterogeneous: this designation may apply to diagnostic categories, but generally the term applies to the sex of the participants. Most therapists employ heterogeneous groups because they most closely reactivate the commonest family constellations. The size of the group may also vary, but it has been found that groups composed of from six to 10 members are most workable; larger groups are unwieldly, and smaller groups do not provide sufficient interaction.

The customary length of a group session is one and one-half hours, if the meetings take place twice a week. When meetings are held on a weekly basis, the time is usually increased to two or two and one-quarter hours. Many therapists employ premeeting and postmeeting sessions, or alternate sessions, during which the patients meet without the therapist. The content of these meetings is discussed in the session with the therapist. (In one of our groups, it was observed that one of the patients said little in the presence of the therapist, but literally spoke a blue streak when he was absent. When this difference was discussed at a group meeting, she related it to the fact that when she was a child, none of the children were permitted to talk when father was in the room.)

The terms open and closed groups refer to time limit and number of patients in the group. Closed groups are limited in duration and in the number of patients, no new members having been added to the original number. Open groups continue indefinitely, new members being introduced as old members complete their therapy or drop out.

The selection of members for a group should be made after the group therapist has become acquainted, through individual sessions, with the patients' problems, past history, family constellation and dynamics. The function of group therapy is explained to the prospective member; objections are noted and worked through; then when ready, the introduction of this new member is discussed by the therapist with those present in the functioning group. To some patients this discussion evokes emotional reactions which occurred at the time a new sibling or a stepparent was introduced into the family.

The question is often asked, "What type of patient is suitable for analytic group therapy?" Experience has shown that all patients, with the

exception of the mentally retarded, the psychopath and the exhibitionist, are appropriate. The patient who has difficulty adjusting in social situations usually profits most from group therapy. Research groups are being utilized in the study and treatment of the psychopath and the schizophrenic.

At the first session or meeting of the group, the members are introduced by their first names, the therapist taking a place in the circle. Some therapists begin the session by throwing out the question, "What do you think about this meeting?" Others wait silently until the most anxious begins talking, so that all productions arise spontaneously from the patients. All communications are treated as the equivalent, on the part of the group, as are the free associations of the individual in analysis. Some therapists maintain a permissive, nondirective attitude—a so-called "blank screen"—entering into the group work to break up disruptive influences in the group or to interpret transference reactions, content, process behavior and relationships.

Classification

Attempts to classify the course of analytic group therapy into stages varies with various therapists. For the purposes of our discussion, we may consider these as being basically three in number:

1. The introductory phase covers the period during which the patients develop "rapport" with one another, by testing the group possibilities. Each member enters the group with his own private, usually narcissistic conceptions, and most frequently with many restrictions, both conscious and unconscious, as to their willingness or ability to participate in group work. The therapist observes their reaction to one another and to himself. He observes the seating arrangement, where members are physically confronted with one another. It is our opinion that the seating position also gives us an indication of the extent of the dependency needs of the patient. This phase may extend through from six to 30 sessions. This stage is explained dynamically as the gradual process that goes on during this primary phase resulting in a lessening of the id gratification of their autistic productions. This process is due to the reality of the presence of others in the group.

2. The intermediary phase corresponds to the periods of childhood and adolescence; it is characterized by increased interaction and transference reactions between the members of the group themselves, as well as being directed towards the analyst. There is a reliving of their family roles and vying with one another in their thematic productions, for example: (a) mixed feelings towards love, (b) hostility, distrust and fear of people, (c) feelings of inferiority and desire to be average, (d) the problem of blaming others (projection) or accepting the responsibilities of their own actions, (e) interest in themselves as a group and examination of the structure and function and (f) engagement in deep analytic interpretation in contrast to superficial taking and giving of advice.

3. The third or termination phase may be considered as the reaching of adulthood or maturity. When working with closed groups, this results in the dissolution of the group. The mechanics and time of the dissolution should be part of the group work. Termination in an open group does not take place for all members at the same time—in fact, an open group may, at any given time, consist of members in all three phases. Each individual proceeds at his own rate of progress, which is largely determined by inner personality structure, the ability to relinquish old defenses against anxiety and to incorporate the changes produced by the effects of treatment. In open group, the termination of therapy, or the patients' desire to leave the group, is a topic for group consideration and discussion. Often, there is a great deal of difficulty encountered by the individual in his feelings about the prospective loss of group support. This separation anxiety must be realistically dealt with in order to enable termination to occur and prevent the development of a neurotic dependency on the group.

Contributions of Group Therapy to Individual Psychiatry

By now, group therapy has justified its existence and contributed substantially to psychiatry. It is assisting and in many instances taking the lead in extending psychiatry's service to mankind. Amongst group therapy's contributions to individual psychiatry may be listed:

1. Therapist's increased awareness of the patient's, as well as his own, relationship to his social environment; recognition of the need to belong to a group—this belonging contributing to a healthier identification, a realistically flexible superego structure and ego growth.

2. Enrichment of over-all knowledge of psycho-

dynamics through the better understanding of the dynamic force of the group process.

3. A better understanding of the observations noted of the patient's interaction in a group setting, such as joint interviews with parent and child and husband and wife.

4. The group experience makes the therapist better able, in the one-to-one situation, to resist being subtly "seduced" into a hierarchical authority role by the patient's transference needs.

5. Greater awareness of the true nature of resistances emerging from interpersonal activity between therapist and patient, so that they are seen as more than mere manifestations of the patient's pathologic state.

Expanding Role of Group Therapy

Analytic group therapy is being utilized with increasing frequency—not only in research in psychiatry—but in other fields. In industry, for example, big business has recognized that there are two major aspects of the human element concerned, namely, labor and management. From the management aspect, industry is concerned with the assistance that can be obtained in personnel selection and training of executives and other specialists. From the labor aspect, big business is concerned with absenteeism, turnover and development of programs for retirement. For example, in Consolidated Edison of New York, alcoholism amongst its employees is treated with group therapy. Major airlines are concerned with emotional problems in their pilots, who are entrusted with million dollar planes and many human lives.

In many educational centers, ancillary services, such as the guidance or mental health services, have utilized group therapy in investigating psychosomatic and other emotional illness in the student population—as well as in preventive and prognostic criteria in mass studies—such as reported from the University of Minnesota by Hinkley and Herman and the Guided Studies Program now in progress at the University of Miami.

In many psychiatric and general hospitals throughout the United States, group therapy is being employed for training, treating and research. Nursing personnel are trained by participating in group programs. The old axiom about a picture being better than a thousand words may be paraphrased as "one group session is worth a dozen lectures."

Many chronic patients who attend many and varied clinics, after being in group therapy a short while, transfer their dependency needs from those clinics to the group and often gradually give up their dependence on the hospital completely.

Penal institutions, such as prisons and reform schools, are utilizing group therapy to study dynamics as well as to attempt to produce characterological changes. Clinics, guidance centers and other group projects, such as the Day Centers for Senior Citizens, are utilizing group therapy not only for treatment but also for research in preventive psychiatry.

From the foregoing description of analytic group therapy, we can see its role as serving a threefold purpose — Research, Training and Therapy.

As a research tool for the critical study and evaluation of group dynamics, several techniques are employed, techniques which could not be utilized in individual therapy. These include the recording of the sessions by either mechanical means, such as a tape or wire recorder, or by observers who observe behavior of the group and therapist, as well as their verbal expressions. At the Institute at Jackson Memorial Hospital, two setups of rooms with two way mirrors have been built into the new building and will be utilized in the training and research that will be applied to group therapy.

In the study of group dynamics, Kubie has pointed out that social forces may determine whether a neurosis is recognized and whether its possessor will seek help. These forces also help shape and alter the evolution of an existing neurosis. It, however, has not yet been determined what role social forces play in the actual beginning of neurosis. Analytic group therapy may become the experimental laboratory for the testing of hypotheses which are being formulated in these areas known as social family psychiatry and in community projects such as guidance centers.

Group therapy will help in the determination of factors which influence change in unconscious behavior. An individual's self image and the role that he plays are best illustrated through group therapy. Research can illuminate more on the effects and utilization of ancillary services, such as social workers and psychologists, as well as the effects of the behavior of therapists, that is, predetermined roles played in group therapy.

From the standpoint of training the psychiatrist, group therapy is a living experience. He is a participant, and it is therefore an experience wherein he may become better aware of his own dynamics. In a training situation, he will be able to study and be shown his own behavior and reactions in a social sense. There will be present an opportunity better to fulfill the implied desire so aptly expressed by Robert Burns:

> O wad some Pow'r the giftie gie us
> To see oursels as others see us!

One of the oldest and most experienced training analysts refers the analysand, upon completion of training on an individual basis, to an analytical group therapist for a finishing course in group therapy, during which the analysand participates in a therapy setting. In one of the New York analytical training institutes, a series of lectures on "Psychoanalysis of Groups" is included in the curriculum, and additional courses are available as electives. These courses exemplify the recognition of the importance of group analysis in the training of therapists.

In the training of group therapists, beginning inexperienced therapists are utilized as group reporters until they have experienced working with groups and are conversant with the role of group therapists before they conduct groups of their own. By means of the methods of recording reactions of individuals in group, special situations can be observed and utilized by the playing back of recordings.

Summary

Group therapy is the discovery and validation of the assets and capacities of each individual in the group in order to help him reach fulfillment by helping him grow to the maximum of his potential and ability, use all his capacities, arrive at a maximum tolerance of frustration and have a high regard for the rights of others. In other words, the aim of analytic group therapy is the same as that of individual psychotherapy—to help the infantile individual to become a mature, productive member of society. We also believe that one of the major differences between the two lies in the management of dependency; individual treatment invariably fosters a special kind of dependency which must eventually be worked through. Group therapy essentially avoids this because of the factors of dilution of the transference and mutual group support. As a modality of therapy, group analysis can fulfill a need which has arisen out of the highly successful and beneficial effects of individual psychotherapy.

As the public has had increased contact with psychiatry and become aware of its potential, there has arisen a shortage of trained personnel to handle the demand. Since, over the years, experience has shown that group analytic therapy is efficacious, it now stands alone as the form of therapy able quantitatively to help more people and also places treatment within the economic capacity of more people to pay for it.

Dr. Bernard Glueck, looking back on his 50 years of psychiatric practice, stated that he has come to feel "that child psychiatry is preventive psychiatry and that group therapy is corrective psychiatry."

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Objectives of Organized Medicine

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Jacksonville

The medical profession is a mixture of art, science, business, craftsmanship and philanthropic work. Behind such a veil of contradictory obligations the physician lives and works in his practice as a member of one of the oldest free professions known to mankind, one which has been subject to great change in this century of natural science, engineering and social security claims.

Until recently the duties of a physician were simple; he cared for his patients as best he could with his limited knowledge and more or less unlimited time. This had been true for 25 centuries, ever since Hippocrates initiated the effort to free medicine from superstition and set it on a sound scientific basis.

Now all this has changed. Our generation of physicians has been, and perhaps those to follow us for a long time will be, forced out of our traditional orbit into many spheres of activity which would have been incomprehensible to our predecessors. Among these many activities are membership in medical and lay organizations, and on numerous committees, councils, commissions and bureaus, ad infinitum.

Oddly enough, these various pursuits are still a part of our duty to our patients since by these works we hope to keep our profession free from government control. The ultimate sufferers under government medicine are the patients themselves. It is axiomatic that the more functions government assumes the less individual freedom any of us, patient or doctor, will have.

Organization

In 1831, Alexis de Tocqueville, a Frenchman, toured our country, and wrote a book on his impressions entitled "Democracy in America." In this book he emphasized the American propensity for forming associations. It is noteworthy that he observed, "Whereever at the head of some new undertaking you see the government in France, or a man of rank in England, in the United States you will be sure to find an association." May this always be true of America.

Like other Americans, physicians, too, formed their associations because it was the one way in which they could be heard. It was a great day for those of us in the profession when the American Medical Association was founded in 1847. It was not until the turn of the twentieth century, however, that the real benefits of this organization began to be appreciated. Since its voluntary actions in exposing the inadequacies and in improving the standards in medical schools, it has provided leadership in medical fields which is appreciated by most doctors of medicine. Naturally,this leadership has been influenced by external pressures and by grass-roots physician activities. It has grown and it has changed with our times because the American Medical Association is but a federation of state associations, and each of these groups can only be reached through membership in a component county medical society. The purposes of each are essentially the same. Organized medicine began in Florida with the founding of the Duval County Medical Society in 1853. Twenty-one years later the Duval and Escambia County Societies organized the Florida Medical Association.

The stated purpose of the American Medical Association is "TO PROMOTE THE SCIENCE AND ART OF MEDICINE AND THE BETTERMENT OF PUBLIC HEALTH." Last year an addition was proposed because of the many changes which have been effected. It adds, "AND AN UNDERSTANDING OF THE SOCIO-ECONOMIC CONDITIONS WHICH WILL FACILITATE THE ATTAINMENT OF THESE OBJECTIVES."

Objectives Outlined

Implementation of the stated purpose reveals four primary objectives with multiple secondary ones under each. The primary ones are:

I. The Maintenance and Improvement of the Standards of Medical Practice and Medical Care

II. The Dissemination of Scientific Material

Secretary Treasurer, Florida Medical Association.

III. The Organization of the Medical Profession

IV. The Study and Implementation of Socio-economic and Political Problems

I. The Maintenance and Improvement of the Standards of Medical Practice and Medical Care

A. Study and Improvement of Individual Health and Public Health

1. Health education (1911)
   Promote continuing education of physicians—postgraduate
2. Check medical tools, appliances, food, drugs, et cetera
   Councils on Physical Medicine and Rehabilitation (1925), Food and Nutrition (1929), and Pharmacy and Chemistry (1906)
3. Encourage physical examinations, promote healthful working conditions and safety, and stimulate health education among workers
   Council on Industrial Health (1938)
4. Encourage doctor readiness in disaster
   Council on Emergency Medical Service (1947)
5. Work for better understanding and care of mentally ill
   Council on Mental Health (1951)
6. Offer advisory services in community health problems
   Committee on Research

B. Evaluation and Improvement of Medical Schools and Hospitals
   Council on Medical Education and Hospitals (1904)

C. Control of Quackery and Proprietary Pharmaceuticals (1906)

1. Investigation of fraudulent claims, cultists, et cetera
   Bureau of Investigation (1936)
   Bureau of Legal Medicine and Legislation (1922)
   Councils on Pharmacy and Chemistry, Food and Nutrition, and Physical Medicine and Rehabilitation

II. The Dissemination of Scientific Material

A. To Physicians

1. Publications (1911)
   Journal of the American Medical Association
   The New Physician
   The AMA News
   Nine specialty journals
2. Library
   Reference library with lending services for periodicals and clippings
   Book reviews and abstracts
3. Meetings
   Scientific sessions
   Scientific exhibits
   Congresses
   Industrial Health
   Rural Health
   Medical Education and Hospitals
   Licensure
4. Motion Pictures

B. To Public

1. "Today's Health" (Most widely read health magazine)
2. Department of Public Relations (1951)
   Magazines
   Press
3. Bureau of Health Education (1911)
   Radio
   Transcriptions
   Television

III. The Organization of the Medical Profession

A. Leadership—Official Spokesman for Medicine

1. House of Delegates (Grass roots control)
2. Board of Trustees
3. Officers
4. Executives

B. Liaison and Communication LOCAL, STATE AND NATIONAL ORGANIZATIONS

C. Ethics

1. Judicial Council (Supreme Court of Medicine)

D. Integration of Groups Within the American Medical Association

1. Specialties and General Practice

E. Determination of Policies on Issues Concerning Medicine (Positive or Negative)

F. Records

1. Directory

IV. The Study and Implementation of Socio-economic and Political Problems and Trends

A. Study and Dissemination of Information

1. Council on Medical Service (1943)
   (Formed to combat socialistic trends of the 1930s)

2. Bureau of Medical Economic Research (1931)
3. Council on Legislation (1922)
   Washington Office
   (Much information about legislation affecting medicine would reach the profession too late or not at all were it not for the Washington Office)

B. Cost of Medical Care
C. Distribution of Physicians
   1. Placement services
D. Insurance (Continues to promote attitude of personal responsibility for health)
   1. Blue Cross and Blue Shield
   2. Medicare and Other Government Plans
   3. Professional Liability
   4. Health and Accident
E. Emergency Medical Service (Council—1947)
   (Doctors have fulfilled their responsibilities to their nation in time of war; the formation of this council insured peacetime cooperation in physician procurement and future emergencies)
F. Medicolegal
   1. Malpractice
   2. Court Testimony
   3. Legal Problems

The stated purpose of organized medicine is implemented in a similar but less detailed manner at the state and county society levels.

It is said that the two items of gravest importance to young men entering the practice of medicine are the purchase of Professional Liability (malpractice) Insurance and Health and Accident Insurance. Consulting the county or state medical society before buying them may prevent future difficulties.

The Physician's Responsibility

There is one fundamental difference between the first two objectives of organized medicine dealing with the art and science of medicine and the last two dealing with organizational, socioeconomic and political matters. These latter programs require personal effort on the part of every physician, not just money in the form of dues as the others do. For instance, it is futile to try to control medicine's relations with the public at the state or national level. The job is one for the individual doctor in his home community with his own patients and fellow citizens.

We must be ever mindful that medicine is granted certain privileges by society for which we accept certain obligations and resopnsibilities. Ours is not a business or trade in the true sense of the word because of the unique function of our profession, that of holding human life in our hands. Unless we are successful in inculcating a sense of personal responsibility for life and health in each indivdiual as well as each physician, we will continue to be the target for socializers and politicians. Ironically, it may be that in recent years medicine has suffered more from its successes than from its failures. Right now, the prolongation of life by the medical profession has brought us our foremost problems of the moment, ones which threaten the loss of our birthright—individual freedom.

The physician who fails to accept his share of the profession's responsibility in public relations, in insurance, in public education on medical subjects, in political activities as well as medical problems is shirking his duty. Many of these problems are not of our choosing, but it was adapt or be lost. Even so, like the lemmings of old, we sometimes seem to be stumbling over each other to drown in the sea of destruction.

Young doctors, you hold the future of medicine in your hands. Arise to the challenge. Join your county, your state and your national organizations and take an active part from the beginning. During your internships and residencies, there will be minimal charges or none at all, and you can enjoy the benefits and privileges of your oganizations. Attend local, state and national meetings that interest you. Visit the scientific and technical exhibits and spend enough time at the House of Delegates or other governing body to observe the democratic functioning of the organization. Enjoy it to the fullest. It will be your organization.

We look forward to having new physicians in Florida as members of their respective county medical societies and of the Florida Medical Association.

415 Medical Arts Building.

ABSTRACTS

Prophylactic Tracheostomy in Aged and Poor Risk General Surgical Patients. By Thomas E. Starzl, M.D., Ph.D., William H. Meyer, M.D., and John J. Farrell, M.D. J. A. M. A. 169:691-695 (Feb. 14) 1959.

This report concerns the prophylactic use of tracheostomy in a series of aged and poor risk patients. For each of these patients a major operation was deemed mandatory, but the prognosis for immediate postoperative survival was poor because of debilitation and independent pulmonary or cardiovascular disease. The objectives of tracheostomy were to allow maximum utilization of pulmonary reserve and to prevent postoperative pulmonary complications. In a recent three month period in one of the general surgical services at Jackson Memorial Hospital in Miami, 11 patients underwent this procedure after various major operations. It was thought that extensive surgery would uniformly have been fatal to this group without the postoperative use of tracheostomy. Eight of the patients were completely rehabilitated. The remaining three died of late complications of the primary disease, and in only one patient did a pulmonary complication materially contribute to death. On the basis of this experience the authors suggest that the judicious use of tracheostomy is a means of extending the limits of operability to include certain aged and poor risk patients who might not otherwise be expected to survive a major surgical procedure.

Titration of the Calcium-binding Capacity of Urine. By Reid H. Leonard, Ph.D., and Arthur J. Butt, M.D. Brit. J. Urol. 30:280-284 (Sept.) 1958.

In renal calculous disease some derangement of the ordinary urine composition is thought to exist. There are relatively few chemical methods which provide specific evidence for evaluation of stone-producing conditions. In this study the authors report that the addition of neutral calcium chloride to urine causes a decrease in hydrogen ion concentration. This decrease can be titrated and calculated as milliequivalents of calcium-binding capacity. The calcium-binding capacity possibly is related to the phosphorus content and is of the same order of magnitude as the calcium content. This calcium-binding capacity may be significant in preventing the formation of calcium-containing stones and determination of this capacity may be helpful in equating efficacy of certain drugs used to increase calcium solubilisation.

On the Importance of "Weasel Words" in Surgical Pathology. By Alvan G. Foraker, M.D. Surg. Gynec. & Obst. 109:637-638 (Nov.) 1959.

With or without the information requested on the usual referral form, the surgical pathologist may not be able to render a diagnosis wholly pleasing to the surgeon in many instances. He may be confronted with an incorrect clinical evaluation of the nature of the lesion, or the biopsy specimen may not be representative of the true nature of the lesion. In some cases the microscopic slides may reveal information of marked ancillary value, but not intrinsically diagnostic. In other instances, the biopsy report may indicate the basic nature of the lesion, but cannot encompass its total biologic potential. Equivocal qualification is at times unavoidable. The surgical pathologist should limit his diagnosis to the findings of his gross and microscopic studies. He should be exact and definite when possible and should qualify his terms when necessary. He should specify what he knows from personal observation. His report should indicate distinctly, for clarification, the points on which he depends on clinical information. The biopsy report should be complete, accurate, and informative, but "weasel words" may be necessary. The surgical pathologist and the clinician should understand the limitations of the facets of medicine they practice. The surgical pathologist is the clinician's consultant for tissue diagnosis. Full cooperation and mutual understanding are just as necessary in this field as they are in other forms of medical consultation.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

PRESIDENT'S PAGE

Preparation for Duty

Regardless of the motives or the excuses that impel or convince individual physicians to seek or accept election to the often thankless position of medical society officer, such offices carry with them a high degree of respect and honor. These latter mantles of office frequently go unrecognized by one's associates in the local county society. "A prophet is not without honor save in his own country, and in his own home."

Having acceded to office, for better or for worse, the county society officer becomes an important cog in the machine that has evolved to promote the general health of the nation's citizens, establish liaison with other constituted bodies, and provide a common defense of its member physicians. This machine is known familiarly as organized medicine, the American Medical Association, whose services, though often criticized, can no more be dispensed with than could a federal government in a union of states. The county society officer therefore has a responsibility to his fellow members, to his community, and to his state and national medical association.

Recognizing these responsibilities, the Florida Medical Association three years ago instituted an annual Conference of County Medical Society Presidents and Secretaries to help prepare such officers more efficiently and intelligently to perform the duties of their offices. The program of the forthcoming conference on January 14 and 15 will include information on American Medical Association Problems and Programs; Florida Medical Association Programs, Councils and Committees; Insurance; Legislation; and the Florida Medical Foundation. In addition there will be a session to permit discussion of the local county society problems of those in attendance. The complete program is printed on page 813 of this issue of The Journal.

All medical society officers are urged to attend this conference. Their fellow physicians should make it possible for them to leave their practices for the weekend in order for them to be present. While no provision has been made for a large number of other physicians, certainly any who are not officers but are interested could be accommodated.

This conference is not brainwashing. This is valuable information for those leaders who have a job to do. Be there!

Leo M. Wachtel

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On Medicine and the Coincidence of a New Year

The young man was standing on the beach, and as each wave spent itself on the sand, his feet were just splashed with the water. He felt good. His mood was expansive, and as he stretched out his arms into the breeze, he knew he was strong. He watched each wave coming towards him. This one was big—this one small. "Look," he thought to himself, "here comes a whopper." His feet were covered, and the wave rolled on further up the sand. It was almost dark, and his stomach was empty, but this was pleasant because in just a moment he would turn and run over the sand and supper would be ready.

Perhaps, had you and I watched him, we would have sensed these things, but we would have wondered further. Waves have been splashing on beaches like this one for so long.

In this somewhat detached mood we can glance toward our own profession. Naturally we can see the task of combating the ills of man. Diseases can be conquered; smallpox and yellow fever are examples. Other ills disappear with time. We are hardly disturbed by the injuries of arrows, spears or even minnie balls. New ills come with each advance—automobile injuries, radiation effects, drug toxicities and all the others yet to come. We apply ourselves to these, as individuals, as organizations and as political groups.

For this necessary division of labor, medicine can split itself up and meet the needs. These divisions must change almost from day to day as new problems come or new discoveries are made. Just as soon as an individual fits himself into a firm niche, almost immediately the boundaries become dim and his bailiwick is threatened. Thus we go running around searching for something tangible and permanent to tie to. In self defense we grab onto status symbols.

To add to this confusion, we as physicians play our role in the sick room and at the same time see our responsibility to a wider circle—the community, the national scene. As physicians we spend our efforts for individuals. As administrators we apply ourselves to groups. These lines of responsibility often seem at odds.

As a profession we are confronted with a need to guard against too firm a grouping or classification among ourselves. We can think more constructively and kindly as individuals toward individuals. Group effort can have a blinding effect

and destroy vision if decisions are made too often according to group classification. There is a fine line between proper control and the creation of minority groups.

The truths which we can see in 1961 are the same as they have always been. As we watch the waves roll in and break on the sand, we accept the challenge of immediate problems. We feel strong. We welcome the certainty of change. We turn and walk on, knowing that human warmth has always been its own reward. If we gain the wisdom to understand, we can find our need.

FRANZ H. STEWART, M.D.

Shall We Lead or Be Led?

An outstanding development of our time has been the specialization and proliferation of the "Medical Family." Basic and social scientists are accepted as essential members of faculties of medical schools and of medical research teams. Hospital administrators, whose responsibilities in the organization and administration of hospital services are constantly increasing, have become a distinct professional group. Nurses have formed themselves into an independent and influential professional body; and before our eyes technologists, physiotherapists and other "auxiliary"personnel are growing into separate "professions." The medical family, in a sense, is divided, but this division does not necessarily have serious disadvantage, particularly to physicians. While there are dangers, there are also saving features. In the provision of medical care to individual patients there can be only one acknowledged leader—the physician. Members of other groups do look to him for leadership, and with him they do work together. A committee of the American Medical Association on "Relationships of Medicine With Allied Health Professions and Services" is giving careful study to this area of interprofessional relations. Its initial report reveals deep understanding. With this quality of organizational leadership, there is every hope that all these professional bodies will continue to stand together and to present a united front.

But, whether we like it or not, agencies and organizations as well as individuals and professional bodies are becoming increasingly involved in medical care. Here the hazards of division are also evident. Up to now most attention has been given to the problem of how much government there is to be in medical services, little to the problem of how or by whom government medical programs are to be administered. This has been true in many states, and on the national scene even for plans sponsored by organized medicine. For example, we physicians are told that the provision of medical and health services to the aged and to the recipients of public assistance is a welfare problem and should be administered by a welfare agency with a welfare point of view. Broad authority is given to this agency in nearly all states for the provision of a wide variety of medical and health services to the public assistance recipients and to the medically indigent aged. According to the dictates of federal law, decisions as to priorities for needed services and the manner of providing them are the responsibility of federal and state welfare agencies. Authority related to a broad, costly and highly important nation-wide medical program therefore is assigned to nonmedical agencies. The options permitted to the states are to accept lay authority for medical programs, to seek medical leadership through consolidation of health and welfare agencies, a risky venture; or to reach this goal through voluntary cooperation in which the welfare agency delegates major medical responsibility to the medically directed health agency.

Fortunately, for Florida the latter is the direction of development in our state. Believing in the rights of states, we cannot be happy at the lack of freedom of choice in such matters. We are confident, however, that our State Departments of Health and Welfare can continue to work together as our lawmakers have indicated they should. We are committed to the belief that medical programs should be under medical direction. It will be in line with a policy adopted by the Florida Medical Association, if the State Welfare Board assigns maximum responsibility for the development and administration of authorized medical programs to the State Board of Health.

And while pondering on "togetherness" and the lack of it in the medical field, we wonder about the multiplicity of state agencies in the health field. In this connection we think that a recommendation of the Governor's Citizens Medical Committee on Health warrants re-emphasis: "While there is at state level a dispersion of responsibility for broad medical and health problems, this Committee holds strongly that at the local level there should be consolidation of all community health programs for the protection and promotion of health, physical and mental. . . . In the opinion of this Committee, the county health departments should be so strengthened that local health services needed by various state agencies could be provided through sound cooperative planning and action. In view of the costs of travel and the maintaining of multiple regional offices, the Committee is satisfied that the recommended consolidated activity at the local level will result in savings and in increased efficiency."

The medical field is served by individuals, by professional bodies, by official agencies and by voluntary agencies. For each, their own activity seems the most important. The total activity, resources and needs are rarely examined. Lack of coordination and the resulting overlapping programs are sources of weakness; every effort leading to understanding and efficient cooperation is a source of added strength. This is an area for medical leadership which has not had adequate attention. If we really believe that medical and health programs should be under medical leadership, as we profess, we, the physicians of Florida and of the United States must be much more vigilant in attaining our goals.

W. T. S.

The Gout

There is no more fascinating aspect of medicine than its history, and of all the diseases of man none offers a more entertaining and absorbing history than that of the gout.

It has been said that among medical historians there are quacks and their actions are just as pernicious as those of other quacks. "Whoever writes a history," said Henry Sigerist, "frivolously or so as to prove a thesis acts like a pseudo scientist who fakes a laboratory report." Gout was often the subject of so much satire that this brief essay may seem frivolous; however, I am innocent on the other counts. The only thesis I wish to prove is that a few days in the old medical library of the College of Physicians and Surgeons may be at least as entertaining for physicians as some Broadway musicals.

From ancient medical manuscripts one might be led to suspect that gout was a common disorder. Hippocrates is credited with having been the first physician to describe gout and he called it "podagra" meaning painful foot. It is, however, also known that this same Greek word was used to designate an affliction of the joints of beasts of burden. Francis Adams, in his splendid translations of the writings of Hippocrates, used the word "gout" freely and said that Hippocrates described gout as "podagra, cheiragra or gonagra" depending on whether foot, wrist or knee was involved. He wrote of "a rich man's and a poor man's gout" and observed that "a young man does not take gout until he indulges in coition," "eunochs do not take gout," and "a woman does not take gout until her menses be stopped."

These aphorisms may alert us to the probability that the father of medicine did not see gout as frequently as his translated writings would make it appear. We can guess, however, that the fault was not Hippocrates' but that of his translator who wrote in an era when clinicians peopled all of Europe with the gouty.

Galen, who lived and worked in Asia Minor and in Rome from 131 to 200 A.D., wrote of "a new form of 'podagra' related to luxurious eating and drinking." He wrote also of the hereditary nature of the disease and attribued it to venery. Then came Aretaeus, the Cappadocian (circa 200 A.D.), who wrote "pain seizes the great toe (and) is dreadful—but if they (patients) recover partly, as if escaped from death they live dissolutely, are incontinent and luxurious in diet." "Collosities form in the joints which are converted into hard, white tophi, like hailstones," "men are more readily affected than women" and "the most com-

mon age is after 35." Finally, "in many cases (gout) has passed into dropsy and sometimes into (asthma)."

Great physicians who recorded their observations were a rarity in ancient times, and several hundred years passed before Alexander of Tralles and Paul of Aegina (525-605 A.D.) described in detail a plant, Hermaodoctylus, used by them in the treatment of podagra. Because of its toxicity they warned that "this plant ought to be used only for those who have urgent business; for it removes rheumatism speedily and after two days at most." In the opinion of some botanists, descriptions of this plant are most like Colchicum autumnale from which colchicine is obtained. Alexander, however, is said to have had 40 different prescriptions which he used according to the particular form of the disease.

For prevention of an attack, Aëtius of Mesopotamia (500 A.D.) recommended: "January—a glass of pure wine every morning; February—eat no beets; March—mix sweets with meat and drink; April—refrain from horse radish; May—no polypus fishes; June—take cold water every morning; July—abstain from venery; August—eat no mallows; September—drink only milk; October—garlic must be eaten; November—bathing is prohibited; December—eat freely of cabbage."

From the work of Smith and Dawson in Egypt, in 1910, we know that the disease existed in antiquity. They found a perfect example of true gout in the mummy of an elderly man who was apparently a member of the local community of foreign Christians. It is, however, strange indeed that not another case was found among 10,000 mummies ranging in time over a period of 7,000 years from the early Nubians to the Christian Copts. Surely then "the gout" could not have been as widely prevalent as early medical writings led us to believe.

From about 600 A.D. recorded medical history appears to contain no remarkable new observations concerning gout until the appearance of the treatise by Thomas Sydenham in 1683. The writings of Hippocrates, however, still formed the basis for medical theory then and for another 200 years. The master could have exerted no greater influence in the next two centuries were he still lecturing in the medical amphitheatres of England and the European continent. To debate his aphorisms was to invite scorn, abuse and ridicule.

"It may be affirmed of this disease," wrote Sydenham, "that it destroys more rich men than poor and more wise men than fools." Regarding the course, "I judge it to proceed from immoderate use of vigorous functions in the heat of youth, by too early use of venery and by a voracious appetite." He recommended moderation of the table and forbade wine, but permitted "a large draught of small beer." He was convinced that a milk diet would prevent gout, but disdained to use it for he thought milk a food unfit for grown persons. The doctors of Sydenham's day appear to have filled all available beds in England with the gouty.

One hundred years later the disease appeared from medical writing to be still rampant throughout England. Indeed, it seemed to have assumed the aspect of a major public health problem, an epidemic. A most provocative pamphlet was published by Dr. William Cadogan, who maintained that the reason gout was so widely prevalent was that it "proceeded from indolence and intemperance and from the vexation which proceeded from both." Because he dared speak out against the established practice of bleeding, purging, sweating, puking and blistering for gout, he was bitterly attacked in the papers. He deplored the customs of his time as favoring the onset of gout and wrote, "If I am not mistaken, the laudable qualities which are at present the most in fashion are keeping mistresses, debauching friends wives, cheating at gaming tables and at New market, indulging in every excess and refinement in eating and drinking and speaking in parliament." Small wonder he lacked a following.

Two great men of letters lived in the same period and their writings must be accepted as a part of the medical history of the times. Wrote the famous actor and author David Garrick in 1771 ". . . I am tight in my limbs and better in my head and my belly is as big as ever. I cannot quit peck and booze. What's life without Sack and sugar. My lips were meant to be licked and if the Devil appears to me in the shape of Turbot and claret, my crutches are forgot and I laugh and eat. . . A Dr. Cadogan has written a pamphlet lately upon ye gout. It is much admired and certainly has its merits. I was much frightened with it for a week; but as sin will outpull repentence when there are passions and palates, I have postponed the Doctor's regimen 'till my wife and I are tete-a-tete and so make ye mortification-complete." Concerning the prevalence of gout,

Cadogan wrote ". . . the gout is so common a disease that there is scarcely a man in the world, whether he has had it or not, but thinks he knows perfectly what it is."

Benjamin Franklin, who had gout, was a contemporary of Cadogan. It was plain that Franklin did not believe that venery was a precipitating factor in gouty arthritis. In a letter to a Mme. Brillon of France written in 1771 he denied that "excessive indulgence in sexual pleasures is the cause of gout" as he had no gout when he was a young man. The onset of his disease occurred at about age 60. He noted the remitting character of the disease and its occurrence after a severe throat infection.

At midnight on October 2, 1770, while suffering with "a Fit of the Gout," Franklin penned the following dialogue which suggests that he was familiar with Dr. Cadogan's dissertation.

F: Oh. What have I done to merit such cruel sufferings.
G: You've eaten and drank too much.
F: Who is it that accuses me?
G: 'Tis I, Gout.
F: What, My enemy in person?
G: Not your enemy.
F: I repeat it, my enemy, for you would not only torment my body but ruin my good name. You reproach me as a glutton and a tippler; now all the world, that knows me, will allow that I am neither one nor the other.
G: The world may think as it pleases, it is always very complacent to itself and sometimes to it's friends; but I very well know that the quantity of meat and drink proper for a man who takes much exercise may be too much for another who never takes any.

F — Franklin
G — Gout

Somewhat removed from all this ribaldry and attended by little medical notice, Karl Wilhelm Scheele, the co-discoverer with Priestley of oxygen, found uric acid in concrements from joints. No particular significance was attached to this finding, and in 1797 William Hyde Wollaston established the association of disturbed uric acid metabolism with gout when he found that chalky stones in gouty joints consisted principally of uric acid.

These discoveries appeared to initiate a radical change in thinking among certain physicians, and in 1819 Charles Scudamore stated that gout was not as common in England as was supposed. Of 2,200 patients in the Royal Infirmary between 1775 and 1800 he found but one with gout. Our modern concept of the disease was evolving. In 1847 Sir Alfred Garrod devised the ingenious "string test." By simply suspending a small piece of string in the blood serum of gouty and normal persons he obtained a deposit of uric acid crystals on the string and was able to show that the blood of gouty persons held more than the normal amount of uric acid.

Finally, Folin and Denis, in 1913, perfected a method for the quantitative determination of blood uric acid which opened the way for the study of the gout in relation to the disturbed "home economics" of uric acid, and the modern period was launched.

I have presented some facts about gout as it appeared before the Christian era and as it developed with Galen, Aretaeus, Alexander of Tralles and Paul of Aegina into a distinct clinical syndrome. Cadogan, with a medical background built on the aphorisms of Hippocrates and a history of error, filled all of England with the gouty. With the discoveries of Scheele, Wollaston, Garrod and Folin the tie to the past was broken and the task of determining the true nature of gout started. I have no regrets about this rupture except that we are no longer consoled as was Sydenham when he wrote ". . . What is a consolation to me and may also be to other gouty persons of small fortunes and slender abilities, is that kings, princes, philosophers and other great men have thus lived and died."

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Simon D. Doff, M.D.

Third Annual Conference
County Medical Society Presidents
and Secretaries
January 14-15, Jacksonville

Marianna Physician Named General Practitioner of Year

Dr. James T. Cook of Marianna was the recipient of the American Medical Association's 1960 General Practitioner of the Year Award, an honor conferred for the first time on a Florida physician. The 44 year old family doctor received a gold medal and a citation at the opening meeting of the House of Delegates of the American Medical Association during the Annual Clinical Meeting in Washington, D. C., on Nov. 28, 1960. He is the second youngest doctor to be so honored and the fourteenth general practitioner to win the award.

In making the presentation of the award, Dr. Julian Price, chairman of the Board of Trustees, said.

"Dr. Jim Cook is typical of the modern physician who combines his talents to bring the best of scientific medicine to the American people yet has unlimited energies to devote to the service of his community.

"We in the medical profession are deeply honored to name Dr. James Cook as the nation's General Practitioner of the Year."

Dr. Cook was born in Porterdale, Ga., on Sept. 27, 1916. The family later moved to Covington where he was graduated from the local high school. In 1937 he received the Bachelor of Arts degree from Emory University in Atlanta and in 1941 the degree of Doctor of Medicine from Emory University School of Medicine. After serving a one year internship at Emory University Hospital, Dr. Cook entered military service and was attached to the Army Medical Corps during World War II. He received five battle stars from Normandy through Germany and the company he commanded was cited for meritorious service during these campaigns. In addition to the Combat Medical Badge, Dr. Cook received the Bronze Star for meritorious service. Upon discharge from military service with the rank of captain in 1945, he entered the general practice of medicine in Marianna.

Since that time Dr. Cook has entered into every facet of the social, business and medical activities of his community. He has been extremely active in Parent-Teacher and in Boy Scout and Girl Scout affairs. He served as the first male president of the Marianna Parent-Teacher Asso-



Dr. James T. Cook of Marianna is escorted to the platform by Dr. Leo M. Wachtel of Jacksonville, President of the Florida Medical Association, to receive the General Practitioner of the Year Award.



Dr. Cook accepts the General Practitioner of the Year Award.

ciation and in 1958 was campaign chairman for the Girl Scouts. Among other organizations he has served in various capacities are the Rotary Club, the Sportsmen's Club, the Methodist Church, and the Civic Music Association.

An avid enthusiast of outdoor activity, Dr. Cook was appointed by Governor LeRoy Collins to the State Board of Parks and Historic Memorials. He is presently serving as secretary of the Board.

In addition to caring for a large general practice, Dr. Cook has found time to be an active and contributing member of the medical community. He has been Chief of Medicine of the Jackson Hospital for many years and served for two years as Chief of Staff. A valuable committee member through the years, he is also a past president of the Jackson-Calhoun County Medical Society.



Dr. Cook is congratulated by Dr. E. Vincent Askey of Los Angeles, President of the American Medical Association.



Dr. and Mrs. Cook exchange congratulations with Major General Howard McC. Snyder, personal physician to President Eisenhower, who was honored for his "lifetime of distinguished service" by the American Medical Association.



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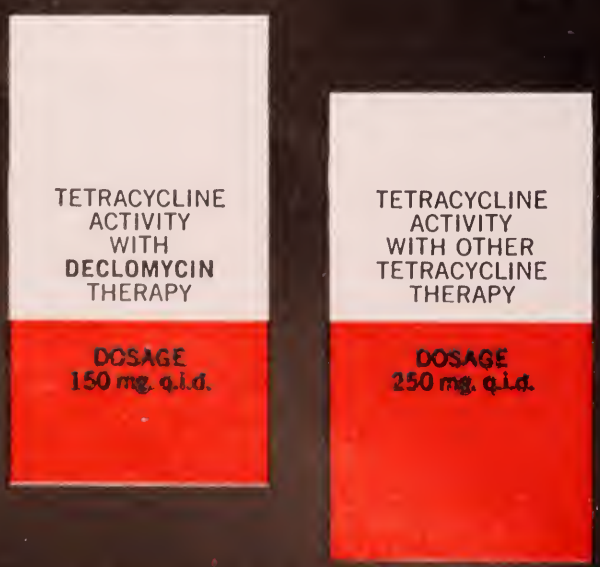
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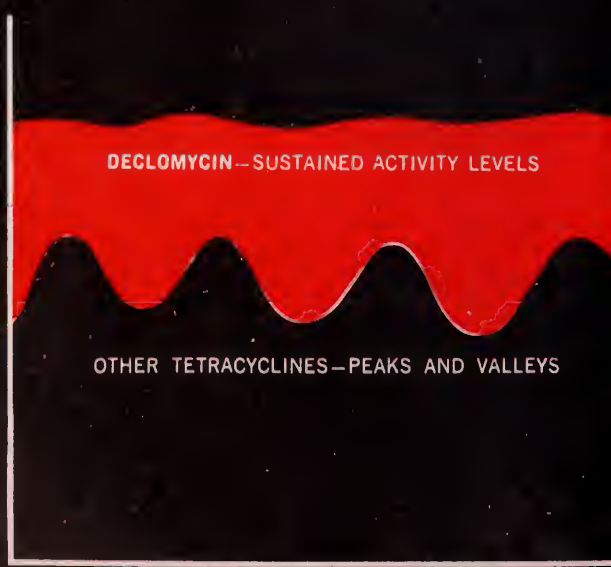
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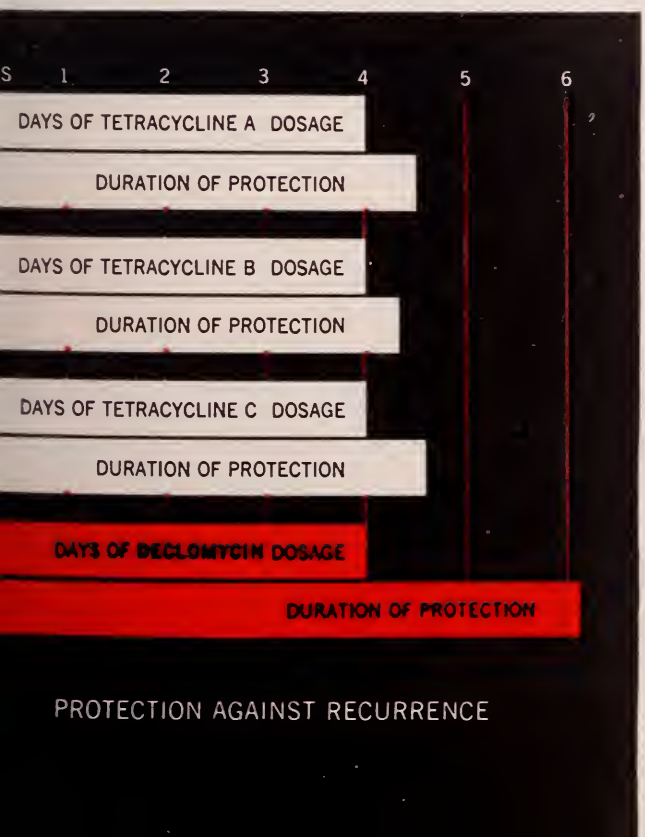
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CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

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Dr. Cook helped organize and is currently a director of a charity heart clinic in Jackson County. For some time this was the only heart clinic serving an area between Jacksonville and Pensacola. His interest in the field of cardiology has resulted in a recent nomination to a second term as a member of the board of directors of the Florida Heart Association, and he is a member of the Clinics Committee and of the Professional Education Committee of the association.

This busy general practitioner has served the Florida Medical Association in various posts with distinction. He is a former Vice President and last year was chairman of the Committee on Liaison with the State Board of Health. For several years he has been a member of the Advisory Committee to the State Board of Health on Medical Scholarships, and is also a member of the newly formed Advisory Committee for Physician Placement for the recipients of these scholarships.

In the field of general practice, Dr. Cook is a member of the American Academy of General Practice and the Florida Academy of General Practice. In 1959 he was made a member of the Board of Directors of the Florida Academy and in 1960 was named president-elect.

For some years Dr. Cook has been an active member of the Florida Medical Committee for Better Government. At the present time he is state chairman of that organization.

The nation's General Practitioner for 1960 plays the violin to the organ accompaniment of his wife, the former Lillian Schwencke of Thomasville, Ga. Their home audience is composed of a son and three daughters, James III, age 16, Karen, age 13, Carol, age 11, and Lillianette, age 10.

Ophthalmology and Otolaryngology Annual Midwinter Seminar Miami Beach, Jan. 29-Feb. 4, 1961

For the fifteenth year, the Florida Midwinter Seminar of Ophthalmology and Otolaryngology will hold its annual meeting in Miami Beach, and again this year the Americana Hotel is headquarters. The Seminar is scheduled for the week of January 29, with presentation of the lectures on Ophthalmology announced for Monday, Tuesday and Wednesday, January 30 and 31 and February 1, and those on Otolaryngology for Thursday, Friday and Saturday, February 2, 3 and 4. The lecture periods begin at 8:30 a.m. and continue to 1:45 p.m. for the ophthalmologists. They begin for the otolaryngologists at 9:00 a.m. and continue to 12:25 p.m., leaving the afternoons and evenings free for recreation. On Wednesday all registrants and their wives will be guests at a cocktail party at the Americana at 6:30 p.m., and the usual informal dinner will follow at 8:00 p.m. This nationally popular midwinter medical event is presented each year in cooperation with the College of Medicine of the University of Florida and the University of Miami School of Medicine.

The ophthalmologists who will lecture and their subjects are: Dr. Walter S. Atkinson, of Watertown, N. Y., "The Choice of Anesthesia for Ophthalmic Surgery," "Local Anesthesia in Ophthalmology," and "Measures Which Decrease Complications in Cataract Surgery;" Dr. William H. Havener, of Columbus, Ohio, "Management of Hyphema," "Clinical Experiences With Light Coagulator," and "Serious Mistakes;" Dr. Charles E. Iliff, of Baltimore, "Tumors of the Eye and Adnexa in Children—Diagnosis and Treatment," "Surgical Technique," and "Contact Lens;" Dr. Irving H. Leopold, of Philadelphia, "Present Status of Anti-infectious Therapy in Ophthalmology," "Therapy of Uveitis," and "Therapy of Vascular Disease in Ophthalmology;" and Dr. Alfred E. Maumenee, of Baltimore, "Mechanism of Action of Procedure to Lower Intraocular Pressure," "Therapeutic Corneal Grafts Versus Conjunctival Flaps" and "Serous Hemorrhagic Detachments of the Macula."

The program for the otolaryngologists will open on Thursday, Friday and Saturday mornings with a buffet breakfast from 7:30 to 8:30 and a question and answer panel entitled "Quiz the Experts." The lecturers for the otolaryngologic portion of the Seminar and their subjects are: Dr. John F. Daly, of New York, "Management of Cancer of the Oral Cavity," "Problems in the Management of the Patient With a Lump in the Neck," and "Parotid Swelling;" Dr. David D. DeWeese, of Portland, Ore., "Chronic Rhinitis and Sinusitis," "Management of Vertigo," and "Facial Nerve Problems;" Dr. Paul H. Holinger, of Chicago, "Recognition and Management of Lower Respiratory and Esophageal Anomalies," "Etiology and Treatment of Chronic Laryngeal Stenosis," and "Bronchoscopic and Esophagoscopic Techniques;" and Dr. Harold F. Schuknecht, of Detroit, "Exploratory Tympanotomy," "Stapedectomy," and "Tympanoplasty."

Third Annual Conference
County Medical Society Presidents and Secretaries
January 14 and 15, 1961

For the third successive year, the incoming presidents and secretaries of the county medical societies will meet this month for a conference sponsored by the Florida Medical Association. The 1961 conference will convene at the Hotel Robert Meyer in Jacksonville on Saturday, January 14, at 2 p.m. and continue through Sunday noon. Although it is planned particularly for the presidents and secretaries at a time when they are assuming their duties for the new year, it will prove helpful and stimulating to all county society officers. Each society will find it advantageous to be well represented at the meeting.

The program covers a wide range of subjects dealing with programs, plans and problems at the national, state and county levels and includes three panel discussions. The formal program on Saturday afternoon will be followed by a reception and dinner in the evening. The Sunday morning session will be devoted to informal discussion of mutual problems, projects and programs by the county society officers.

SATURDAY, JANUARY 14: AFTERNOON SESSION

Leo M. Wachtel, President, Florida Medical Association, Presiding

1:00 p.m.	Registration	
1:30 p.m.	Welcome to Assembly (Purpose of Meeting)	Leo M. Wachtel, M.D.
1:45 p.m.	American Medical Association—Current Problems and Programs	Ernest B. Howard, M.D.
2:05 p.m.	Questions and Answers	
2:15 p.m.	Responsibilities of County Medical Societies	Jere W. Annis, M.D.
2:30 p.m.	Florida Medical Association Programs	Panel Presentation
	Council on Medical Services	Marion W. Hester, M.D., Chairman
	Scientific Council	Thad Moseley, M.D., Chairman
	Judicial Council	Homer L. Pearson Jr., M.D., Chairman
3:00 p.m.	Questions and Answers	
3:15 p.m.	Legislative Programs and Indigent Medical Care	Panel Presentation
	Council on Legislation and Public Agencies	H. Phillip Hampton, M.D., Chairman
	Committee on State Legislation	Edward R. Annis, M.D., Chairman
	Indigent Medical Care	Wilson T. Sowder, M.D., State Health Officer
3:45 p.m.	Questions and Answers	
4:00 p.m.	Florida Medical Association Investment Trust and Insurance Programs	Panel Presentation
	Investment Trust Committee	Floyd K. Hurt, M.D., Chairman
	Pan-American Life	Mr. James E. Devaney
	Marsh and McLennan	Mr. Edward A. Hightower
4:30 p.m.	Questions and Answers	
4:45 p.m.	Fee Schedules—Blue Shield—Commercial Health Insurance	Panel Presentation
	Fee Schedules Committee	Robert E. Zellner, M.D., Chairman
	Blue Shield	Russell W. Carson, M.D., President
	Committee on Commercial Health Insurance	Duncan T. McEwan, M.D., Chairman

5:15 p.m.	Questions and Answers	
5:30 p.m.	Florida Medical Foundation	John D. Milton, M.D.
6:00 p.m.	Cocktails	
7:00 p.m.	Dinner	

SUNDAY, JANUARY 15: MORNING SESSION

S. Carnes Harvard, M.D., President-Elect, Florida Medical Association, Presiding

9:00 a.m. to 12:00 noon	The morning session will be devoted to county medical society officers for discussion of their programs and problems
12:00	Adjournment

Cardiovascular Seminar
Jacksonville, Jan. 26-28, 1961

The Eighth Annual Seminar on Cardiovascular Diseases will be held at the Prudential Auditorium in Jacksonville on January 26, 27 and 28, 1961. This is a yearly presentation of the Northeast Florida Heart Association. This Seminar is presented in cooperation with the College of Medicine of the University of Florida, the Florida State Board of Health and the Florida Medical Association. The American Academy of General Practice allows 15 hours' credit in category I for attendance at this Seminar.

The general registration fee is $10. Medical students, interns, resident physicians and physicians in the armed forces are invited to attend without charge.

The participating physicians are Dr. William Dock, Professor of Medicine, State University of New York College of Medicine; Dr. Lewis Dexter, Assistant Professor of Medicine, Harvard Medical School; Dr. Milton Rosenbaum, Professor and Chairman, Department of Psychiatry, Albert Einstein College of Medicine; Dr. Richard Ebert, Professor and Chairman, Department of Medicine, University of Arkansas School of Medicine; Dr. G. Schiebler, Assistant Professor, Department of Pediatrics, College of Medicine, University of Florida and Dr. J. Gordon Scannell, Assistant Clinical Professor of Surgery, Harvard Medical School.

There will be group luncheons in the St. Johns Room of the Prudential Building on Thursday and Friday. The speakers will be announced later. A banquet will be held on Friday night, January 28, at the George Washington Hotel. Wives and guests are invited to this banquet.

The downtown headquarters will be at the George Washington Hotel, and reservations may be obtained by writing to the hotel. Other information may be obtained by writing directly to the Northeast Florida Heart Association, 1628 San Marco Boulevard, Jacksonville.

The program is as follows:

EIGHTH ANNUAL CARDIOVASCULAR SEMINAR
PRUDENTIAL BUILDING, JACKSONVILLE, JANUARY 26, 27 and 28, 1961

THURSDAY, JANUARY 26

8:30	Registration	
9:15	Welcome and Announcements	Dr. Daniel R. Usdin
9:30	Aortic Stenosis	Dr. Dexter
10:05	Pulmonary Insufficiency	Dr. Ebert
10:40	Recess	
11:00	Diagnosis and Treatment of Cardiac Arrhythmias in Childhood	Dr. Schiebler
11:30	Clinical Pathological Conference Dr. C. Merrill Whorton, Pathologist	Dr. Dock
12:30	Luncheon, St. Johns Room	
2:00	Atherosclerosis, Pathogenesis and Prevention	Dr. Dock

2:30	Late Results of Mitral Valvulotomy and Methods of Treating Recurrences	Dr. Scannell
3:00	Recess	
3:15	Clinical Findings in the Most Common Forms of Congenital Heart Disease	Dr. Schiebler
4:00	Panel: Pulmonary Hypertension	Drs. Dexter, Dock, Ebert, Scannell

FRIDAY, JANUARY 27

9:00	Medical Aspects of Shock	Dr. Ebert
9:35	Pulmonary Embolism	Dr. Dexter
10:10	Recess	
10:30	Role of Emotional Factors in Congestive Heart Failure	Dr. Rosenbaum
11:05	Panel: Progressive Coronary Disease	Drs. Ebert, Dock, Dexter, Rosenbaum
12:00	Luncheon	
1:30	Clinical Coronary Disease	Dr. Dock
2:10	Congenital Heart Disease in Adult Surgical Population	Dr. Scannell
2:50	Recess	
3:00	The Natural History of Mitral Valve Disease	Dr. Dexter
3:30	Individual Group Discussions	

These group discussions will provide the opportunity for more informal discussion with the participating physicians. Each registrant will be free to select the group most suited to his interests.

SATURDAY, JANUARY 28

9:00	The Relationship of the Doctor to the Patient in the Psychosomatic Disorders	Dr. Rosenbaum
9:35	Long Term Prognosis of Patients With Myocardial Infarction Together With the Results of Anticoagulants	Dr. Ebert
10:10	Question and Answer Period	Drs. Ebert, Dock, Dexter, Scannell

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Southeastern Surgical Congress Meeting
Miami Beach, March 6-9, 1961

After its overwhelmingly successful meeting in Miami Beach in 1959, the Southeastern Surgical Congress will return to the Deauville Hotel in that city on March 6 to 9 for its 1961 annual meeting. The program this year will be just as outstanding as previously, featuring the Forum in Surgery as well as symposiums on Diverticulitis and Gallbladder Disease.

Specially invited internationally known surgeons scheduled to appear on the program and the subjects of their lectures are: Dr. Warren H. Cole, of Chicago, "Surgical Aspects of Jaundice" and "Intestinal Obstruction;" Dr. Owen H. Wangensteen, of Minneapolis, "The Extended Operation for Alimentary Tract Cancer" and "Local Gastric Cooling in the Control of Massive Gastric Hemorrhage;" Dr. Richard B. Cattell, of Boston, "Management of Cancer in the Pancreas" and "Benign Strictures of Bile Ducts;" Dr. John M. Waugh, of Rochester, Minn., "The Choice of Operation and Management of Carcinoma of the Rectum" and "Operations for Chronic Pancreatitis;" Dr. Howard A. Patterson, of New York, "The Clinical Behavior of Carcinoma of the Cecum" and "Unusual Surgical Lesions of the Stomach;" and Dr. Harris B. Schumacker Jr., of Indianapolis, "Management of Peripheral Arterial Embolism" and "Pulmonary Valvulotomy—With Extracorporeal Circulation or Not?"

Speakers from Florida will include Dr. Paul Jordan Jr. of the University of Florida College of Medicine, Gainesville; Dr. John J. Farrell and Dr. Clinton L. Border Jr. of the University of Miami School of Medicine, Miami, and Dr. Theodore L. Batchelder of Jacksonville. Those who will also appear on the program as discussers will include Drs. Russell B. Carson of Fort Lauderdale; Jesse W. Castleberry of Orlando, and Dr. James H. Ferguson of Miami.

Renal Symposium at Orlando March 10-11, 1960

An outstanding program of broad interest is scheduled for Orlando in March when the Orange County Medical Society hosts a renal symposium. Five eminent speakers will present a well rounded discussion on various aspects of renal problems at the Cherry Plaza Hotel on March 10 and 11.

Fireside Conferences with the guest speakers will open the scientific program, Friday, March 10 at 8 p.m. The program for Saturday includes addresses by the guests on specific phases of renal problems. The entire session should be attractive to all physicians regardless of their field or specialization. As in the past, plans are being made to get approval by the American Academy of General Practice for six hours' credit, category I.

While the symposium is in session, entertainment will be provided for the ladies by the Woman's Auxiliary. Relaxation for doctors will include a golf tournament on Friday, a luncheon on Saturday, and a cocktail party and banquet with the wives on Saturday night.

The complete program will be announced at a later date. Until then, mark your calendar to attend the seventh annual Central Florida Medical Meeting, March 10-11, Cherry Plaza Hotel, Orlando.

Joint Committee for Placement Of Refugee Cuban Physicians

The Council on Medical Education and Hospitals of the Florida Medical Association at its meeting on Nov. 6, 1960 recommended that the President of the Association take immediate action in setting up a joint committee to assist refugee physicians from Cuba in finding employment in whatever capacity is available. Dr. Walter J. Glenn Jr. of Fort Lauderdale is chairman of the Council.

Acting upon the Council's recommendation, Dr. Leo. M. Wachtel, President, proposed "the establishment of a joint committee to assist in resolving the current problem of Cuban refugee physicians residing in Florida, and that an ad hoc committee be appointed, composed of a representative of the Florida Medical Association, Florida Hospital Association, State Board of Medical Examiners, Florida State Board of Health, and the Governor's Office." Dr. Wachtel further proposed that representatives of the United States Immigration Service, United States Public Health Service and the Veterans Administration be called upon, in an advisory capacity, if deemed advisable by the committee.

The proposal by Dr. Wachtel was unanimously approved by the Executive Committee of the Florida Medical Association on November 8. Subsequently Dr. Wachtel selected Dr. Franklin J. Evans of Miami to represent the Association and to serve as temporary chairman of the committee. The Florida State Board of Health designated Dr. John D. Milton of Miami, its president; the Florida Hospital Association designated Mr. Samuel Gertner, executive director, Mount Sinai Hospital, Miami Beach; the State Board of Medical Examiners designated Dr. Robert T. Spicer of Miami, and Mr. Warren Harper was selected by Governor Leroy Collins to represent his office.

American Medical Association 1960 Clinical Meeting Report of Delegates

The Fourteenth Clinical Meeting of the American Medical Association convened in Washington on Nov. 28, 1960, and continued through December 1. This four day annual gathering in the attractive setting of the nation's capitol had a total registration of 8,170. Of this number 3,940 were physicians and 4,239 were guests.

Signally honored at this meeting was a Florida physician, 44 year old Dr. James T. Cook of Marianna, who was named 1960 General Practitioner of the Year. This award was conferred upon Dr. Cook for his dedication to both medical practice and service to the community. He is the fourteenth recipient of the award and the first Florida physician to be so honored.

Speaking at the Monday opening session, Dr. E. Vincent Askey of Los Angeles, President, called upon the delegates to support not only existing programs of the American Medical Association but also expansion of new programs necessary to meet the challenges of society. Dr. Askey assured the new administration in Washington of cooperation whenever and wherever possible but emphasized that the Association will not change its policies merely for the sake of conformity.

Among the major subjects acted upon by the House of Delegates at the Washington meeting were a scholarship and loan program for medical students, the status of foreign medical graduates,

an American Medical Association dues increase, the expansion of voluntary health insurance, health care for the aged, and new developments in polio vaccine.

Scholarship and Loan Program

The House of Delegates approved a scholarship and loan program proposed by the Special Study Committee of the Council on Medical Education and Hospitals, and also urged that there shall be local participation in the program at the state and county level. In commenting on the two part program, the House approved the following statement by the reference committee:

"This proposed program will provide concrete evidence of the American Medical Association's sincere desire to attract increasing numbers of well qualified young people to enlarge the ranks of our profession. Your reference committee recognizes that the program is wisely designed to allow for its enlargement through the support of individual physicians and other groups. Your reference committee was impressed with the enthusiastic support of this proposal indicated during the course of the discussion. There was indicated a desire that in the final formulation of the administrative details of this program, provision be made for widespread participation by individual physicians as well as county and state medical societies. The program will clearly assist in securing highly talented individuals whose ability and leadership in all areas of medicine will be fostered and at the same time will bring needed financial assistance on a broad basis to medical students under a system in keeping with this Association's belief in individual responsibility."

Foreign Medical School Graduates

Meeting the problem of foreign medical graduates, the House of Delegates adopted a report which included the following statement:

"In order that those foreign physicians who have not yet been certified by the Educational Council for Foreign Medical Graduates might be given further opportunity to enhance their medical education, hospitals would be encouraged to develop special educational programs. Such programs must be of educational worth to the foreign graduate and must divorce him from any responsibility for patient care. Foreign physicians may participate in these programs until June 30, 1961, with approval of the Department of State so that their exchange visa will not be withdrawn before that time. This will also allow the non-certified foreign physician the opportunity to take the April, 1961, Educational Council for Foreign Medical Graduates examination."

American Medical Association Dues Increase

The House approved a Board of Trustee report which announced that a dues increase would be recommended at the annual meeting in June 1961. The report indicated that the amount would be not less than $10 and not more than $25 to be effective Jan. 1, 1962. The Reference Committee asked the Board to consider an increase in the annual dues of $20, to be implemented over a period of two years: $10 on Jan. 1, 1962, and $10 additional on Jan. 1, 1963.

The House suggested that these funds be used to inaugurate or expand a number of programs including:

1. Financial assistance to medical students.
2. Continuing education for practicing physicians.
3. Health advice to the lay public.
4. Medical research.
5. The expansion by the Communications Division of its program of faithfully portraying the image of the American Medical Association.

It is important, the House emphasized, that the Board of Trustees report recommending a dues increase be transmitted in essence to the grass roots level.

Voluntary Health Insurance

In place of a Board of Trustees report and three resolutions, the House adopted the following substitute resolutions:

"Whereas, It has been widely recognized that voluntary health insurance is the primary alternative to a compulsory governmental program; and

"Whereas, The public has shown its confidence in this voluntary system; and

"Whereas, Current social, political and economic developments compel a new and revitalized effort to make voluntary health insurance successful; and

"Whereas, the American Medical Association has consistently pledged itself to make available the highest type of medical care; therefore be it

"*Resolved,* that the House of Delegates direct the Board of Trustees and the Council on Medical Service to assume immediately the leadership in consolidating the efforts of the American Medical Association with those of the National Association of Blue Shield Plans, the American Hospital Association and the Blue Cross Association into maximum development of the voluntary, nonprofit prepayment concept to provide health care for the American people; and be it further

"*Resolved,* that similar leadership be undertaken to coordinate the efforts of private insurance carriers through conferences with their national organizations; and be it further

"*Resolved,* that, where feasible, efforts be made to cooperate with representatives of other types of medical care plans, other professional groups, and representatives of industry, labor and the public at large."

Health Care for the Aged

The House reaffirmed the Association's support of the Kerr-Mills Bill, which was passed last summer, and its opposition to any legislation involving the use of the Old Age Survivors Disability Insurance mechanism for medical aid to the aged. The delegates also urged all state and local medical societies to cooperate with the appropriate state officials and provide leadership in implementing the provisions of the Kerr-Mills Bill.

In connection with health care for the aged, the House suggested further experimentation in home care programs, homemaker services and

visiting nurse services. The delegates also recommended an increased emphasis at all levels of medical education on the new challenges being presented to physicians in the health care of older persons.

Polio Vaccine

The House agreed with a Board of Trustees report which said:

"In view of the fact that oral polio vaccine will not be generally available in sufficient quantity in 1961 for any large scale immunizing effort, the Board of Trustees of the AMA strongly recommends that the medical profession encourage the widest possible use of the Salk vaccine for the prevention of poliomyelitis. The Salk vaccine has been proved to be effective and since there are still many segments of the population not immunized against poliomyelitis every effort should be made to encourage the general public to take advantage of the Salk vaccine without delay."

The Board report was amended to suggest that a proper committee be established by the American Medical Association to study the problems involved in administration of the new oral polio vaccine and to establish guides for physicians to follow when they are approached by various groups and asked for their support in administering oral polio vaccine.

Miscellaneous Actions

In considering a wide variety of resolutions and annual and supplementary reports, the House also:

Approved continuing study and periodic re-evaluation of the trend toward locating physician's offices in or adjacent to hospitals;

Directed the Committee on Medical Care for Industrial Workers to carry out its duties as previously instructed and to prepare guides for physician relationships with medical care plans in conformity with the clear policies already laid down by the House of Delegates;

Approved a set of guides relating to drug expenditures for welfare recipients;

Asked the Board of Trustees to study the question of blood replacement responsibility and also the matter of establishing health insurance fee schedules for surgical assistants;

Urged the Board to make every effort to reduce the number of physicians who are non-dues-paying members and approved a three year study report on the relationships of physicians not-in-private-practice to organized medicine;

Requested the Board to present a completed retirement and disability insurance program for members of the American Medical Association at the June 1961 meeting, and

Agreed that the General Practitioner of the Year Award should be continued as at present.

Respectfully submitted,
Reuben B. Chrisman Jr., M.D., Chairman
Francis T. Holland, M.D.
Meredith Mallory, M.D.
Burns A. Dobbins Jr., M.D.

BLUE SHIELD

Medicine—And Today's Challenge

Twenty years ago, the medical profession responded to an urgent challenge, and demonstrated that doctors—working together with labor, industry and community leaders—could solve a great social problem by voluntary effort.

The challenge faced in the Forties was the threat of national compulsory health insurance, which many people then thought was the only practicable solution to the problem of prepayment for modern medical care.

Medicine's response was the creation of Blue Shield, through which the profession acknowledged its responsibility not only to provide good medical care but to help people pay for it when they need it. Although Blue Shield has always been the leader and pace setter of the vast voluntary medical prepayment system, its efforts were soon supplemented by the private insurance industry, which today underwrites about as much medical care insurance as do the nation's Blue Shield Plans.

Now the profession faces a new challenge in the proposal to utilize the Social Security system to underwrite medical care for its aged beneficiaries. There are many who fear that this would be only a preliminary step to the extension of medical care coverage through Social Security to the entire population.

How can medicine meet this new challenge? Why not look again to Blue Shield, medicine's own prepayment mechanism? Blue Shield today has earned a vote of confidence from more than 45 million citizens and it also enjoys substantial —though not uncritical—support from much of labor and industry.

Blue Shield programs vary widely in scope of coverage, in the degree of assurance of full payment that they offer the patient, and in the adequacy of their payments to physicians. Some Plans across the nation are very good, while some

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others are scarcely worthy of public support or professional endorsement. If physicians are to meet today's challenge and keep their patients and the profession free of political domination, they must make the Blue Shield Plan as good as the best of them. Failure to provide the people with the very best medical prepayment program that can possibly be offered will cause them to look elsewhere for the answer to this challenge.

OTHERS ARE SAYING

Medical Care Versus Doctor Care

As discussion of legislation in relation to care of the sick commences in the first year of the new decade it is probable that the publicity relating to it will repeat the errors of former years.

We refer to the indiscriminate use of the terms "medical care" or "medical services" when those services rendered by doctors only are referred to. Why is this important? It is important because people are prone to forget that no one but a physician can give them "doctor care."

On the other hand, "medical care" is a broad term. It includes the services of hospitals, nurses, medicines, dentists, and paramedical technicians, to name but a few.

So when the political orators begin again to bring up the costs of "medical care," let those costs be broken down in such a way that the public knows what "doctor care" as opposed to "medical care" in general is costing them.

If this is done, it may surprise many to know that out of what is called "the medical dollar" the physician receives somewhat less than twenty-five cents. During the past ten years doctors' fees have not increased in proportion to the other items included in the cost of living index.

New York State Journal of Medicine
60:500 (Feb. 15) 1960

STATE NEWS ITEMS

Physicians in the Miami area serving on local committees for the Twenty-Eighth Annual Meeting of the American Academy of Orthopaedic Surgeons being held at Bal Habour January 8-13 include Dr. Edward W. Cullipher of Miami, general chairman; Dr. Robert P. Keiser of Coral Gables, vice-chairman; Dr. Lyle W. Russell of Miami, instructional courses; Dr. Elwin G. Neal

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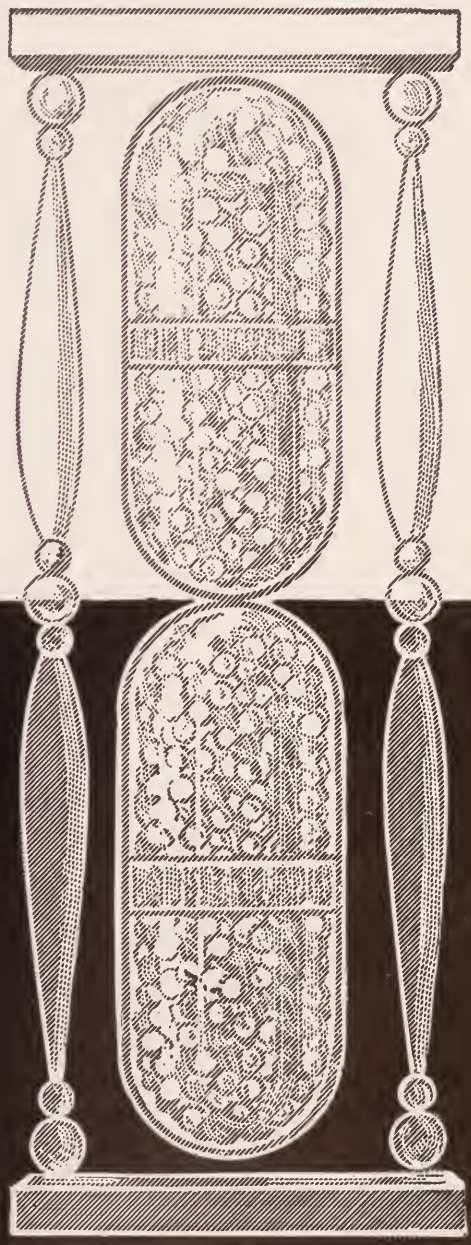
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of Miami Shores, audio-visual; Dr. Leon H. Mims Jr. of Miami, technical exhibits; Dr. Charles R. Burbacher of Coral Gables, registration; Dr. Arthur H. Weiland of Coral Gables, scientific meeting; Dr. Wallace E. Miller of Miami, scientific exhibits, and Drs. Lester A. Russin of Miami Beach and Arturo C. Ortiz of Miami, publicity.

Dr. John A. Speropoulos of Miami has been elected president of Florida Hellenic Physicians. Dr. John M. Canakaris of Bunnell has been chosen to serve with Dr. Speropoulos as vice president, and Dr. Pete G. Felos of Starke as secretary.

A postgraduate course on "Problems of the Newborn Infant" is scheduled for January 24-26 at the Medical College of Georgia, Augusta. The course is acceptable for 18 hours credit, Category I, by the American Academy of General Practice. Information is available from Dr. Claude-Starr Wright, Department of Continuing Education, Medical College of Georgia, Augusta, Ga.

Dr. James T. Shelden of Lakeland has been elected president of the Florida West Coast Radiological Society for the year 1960-1961. Dr. Richard V. Meaney of Bradenton has been chosen as vice president, and Dr. Joseph C. Rush of Clearwater as secretary-treasurer.

Dr. Nathaniel M. Levin of Miami has completed recently an advanced postgraduate course in surgery of the stapes and other aspects of otologic surgery which was presented at the Temple University Medical Center at Philadelphia.

Six additional Fellowships for Residents in Ophthalmology, to be awarded July 1, 1961, have been announced by the Guild of Prescription Opticians of America. Each Fellowship is for a total of $1,800 payable in monthly stipends over the period of a three year residency. The grants are limited to residencies at approved institutions where full three year residencies are offered, but residencies which begin anytime during the calendar year are eligible. Application forms and other information are available by writing to Fellowships, Guild of Prescription Opticians of America, Inc., 110 East 23rd Street, New York 10, N. Y.

Dr. Frederick E. Hasty of Coral Gables assisted in the presentation of a postgraduate course

(Continued on page 832)

A vine, someone said, is like the human mind–always reaching out for new things to grasp.

PROGRESS...

One way or another people will seek out new ways to cope with old problems. Yet progress must be wisely guided. One doctor says: "The desire of the public to have prepayment medical protection is so urgent that it will buy this protection from whatever plan seems most enticing. Whether you like it or not, prepayment medical care is here to stay. Let us support the system which is voluntary and over which we have adequate control." **BLUE SHIELD**®

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5. does not impair mental efficiency or normal behavior

Miltown®

meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.
Also as MEPROLABS® — 400 mg. *unmarked*, coated tablets; and as MEPROSPAN® — 400 mg. and 200 mg. *continuous release* capsules.

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®TRADE-MARK

of clinical use...



...for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a ***known*** drug. Its few side effects have been fully reported. ***There are no surprises in store for either the patient or the physician.***

NEW analgesic

Kills pain



stops tension

For neuralgias, dysmenorrhea, upper respiratory distress, postsurgical conditions... new compound kills pain, stops tension, reduces fever—gives more complete relief than other analgesics.

Soma Compound is an entirely new, totally different analgesic combination that contains three drugs. First, Soma: a new type of analgesic that has proved to be highly effective in relieving both pain and tension.* Second, phenacetin: a "standard" analgesic and antipyretic. Third, caffeine: a safe, mild stimulant for elevation of mood. As a result, the patient gets more complete relief than he does with other analgesics.

Soma Compound is nonnarcotic and nonaddicting. It reduces pain perception without impairing the natural defense reflexes.*

NEW NONNARCOTIC ANALGESIC

soma® Compound

Composition: Soma (carisoprodol), 200 mg.; phenacetin, 160 mg.; caffeine, 32 mg.
Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 apricot-colored, scored tablets.

NEW FOR MORE SEVERE PAIN

soma® Compound + codeine

BOOSTS THE EFFECTIVENESS OF CODEINE: Soma Compound boosts the effectiveness of codeine. Therefore, only ¼ grain of codeine phosphate is supplied to relieve the more severe pain that usually requires ½ grain.

Composition: Same as Soma Compound plus ¼ grain codeine phosphate.
Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 white, lozenge-shaped tablets; subject to Federal Narcotics Regulations.

References available on request.

WALLACE LABORATORIES • Cranbury, N. J.

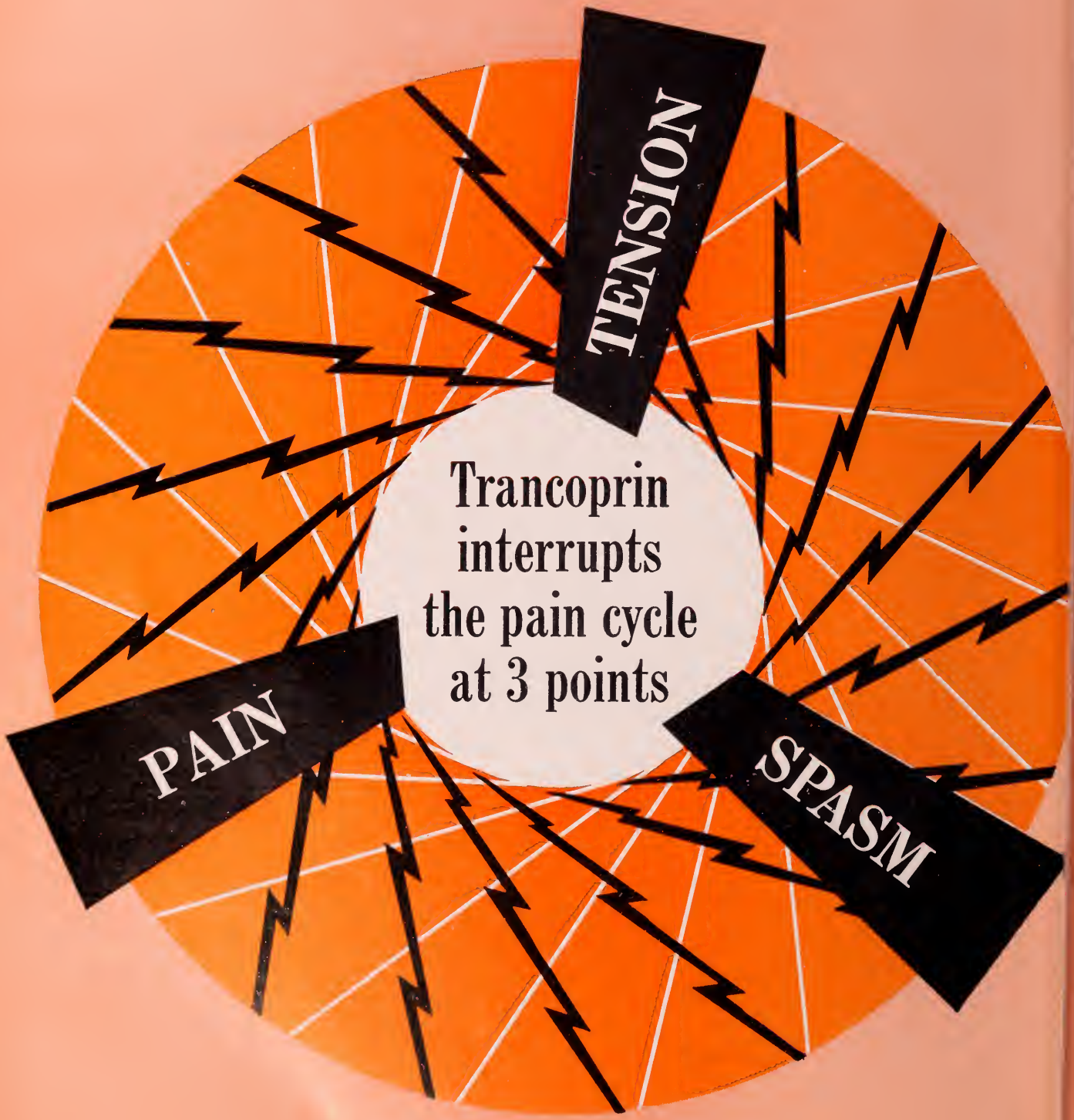
1963

announcing...

Trancoprin

acetylsalicylic acid (300 mg.) and chlormezanone (50 mg.)

Tablets



a broad spectrum non-narcotic analgesic

Trancoprin, a new analgesic, not only raises the pain perception threshold but, through its chlormezanone component, also relaxes skeletal muscle spasm[1-6] and quiets the psyche.[2,3-5,7]

The effectiveness of Trancoprin has been demonstrated clinically[8] in a number of patients with a wide variety of painful disorders ranging from headache, dysmenorrhea and lumbago to arthritis and sciatica. In a series of 862 patients,[8] Trancoprin brought excellent or good relief of pain to 88 per cent of the group. In another series,[9] Trancoprin was administered in an industrial dispensary to 61 patients with headache, bursitis, neuritis or arthritis. The excellent results obtained prompted the prediction that Trancoprin "... will prove a valuable and safe drug for the industrial physician."[9]

Exceptionally Safe

No serious side effects have been encountered with Trancoprin. Of 923 patients treated with Trancoprin, only 22 (2.4 per cent) experienced any side effects.[8,9] In every instance, these reactions, which included temporary gastric distress, weakness or sedation, were mild and easily reversed.

Indications

Trancoprin is recommended for more comprehensive control of the pain complex (pain → tension → spasm) in those disorders in which tension and spasm are complicating factors, such as: headaches, including tension headaches / premenstrual tension and dysmenorrhea / low back pain, sciatica, lumbago / musculoskeletal pain associated with strains or sprains, myositis, fibrositis, bursitis, trauma, disc syndrome and myalgia / arthritis (rheumatoid or hypertrophic) / torticollis / neuralgia.

Dosage

The usual adult dosage is 2 Trancoprin tablets three or four times daily. The dosage for children from 5 to 12 years of age is 1 tablet three or four times daily. Trancoprin is so well tolerated that it may be taken on an empty stomach for quickest effect. The relief of symptoms is apparent in from fifteen to thirty minutes after administration and may last up to six hours or longer.

How Supplied

Each Trancoprin tablet contains 300 mg. (5 grains) of acetylsalicylic acid and 50 mg. of chlormezanone [Trancopal® brand]. Bottles of 100 and 1000.

Trancoprin Tablets / non-narcotic analgesic

References: 1. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 2. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 2:1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960. 5. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 6. Mullin, W. G., and Epifano, Leonard: *Am. Pract. & Digest Treat.* 10:1743, Oct., 1959. 7. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 8. Collective Study, Department of Medical Research, Winthrop Laboratories. 9. Hergesheimer, L. H.: An evaluation of a muscle relaxant (Trancopal) alone and with aspirin (Trancoprin) in an industrial medical practice, to be submitted.

Winthrop LABORATORIES, New York 18, N. Y.

Trancoprin and Trancopal (brand of chlormezanone) trademarks reg. U.S. Pat. Off.



WHENEVER COUGH THERAPY
IS INDICATED

HYCOMINE®

Syrup

THE COMPLETE Rx FOR COUGH CONTROL

cough sedative | antihistamine
decongestant | expectorant

■ relieves cough and associated symptoms in 15-20 minutes ■ effective for 6 hours or longer ■ promotes expectoration ■ rarely constipates ■ agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE* Syrup contains:

Hycodan®		
Dihydrocodeinone Bitartrate	5 mg.	6.5 mg.
(Warning: May be habit-forming)		
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law permits oral prescription.

Literature on request

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ENDO LABORATORIES
Richmond Hill 18, New York

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BAYER

1¼ Grs. Ea.
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Living up to a family tradition

There are probably certain medications which are special favorites of yours, medications in which you have a particular confidence.

Physicians, through ever increasing recommendation, have long demonstrated their confidence in the uniformity, potency and purity of Bayer Aspirin, the world's first aspirin.

And like Bayer Aspirin, Bayer Aspirin for Children is quality controlled. No other maker submits aspirin to such thorough quality controls as does Bayer. This assures uniform excellence in both forms of Bayer Aspirin.

You can depend on Bayer Aspirin for Children for it has been conscientiously formulated to be the best tasting aspirin ever made and to live up to the Bayer family tradition of providing the finest aspirin the world has ever known.

Bayer Aspirin for Children—1¼ grain flavored tablets—Supplied in bottles of 50.

● We welcome your requests for samples on Bayer Aspirin and Flavored Bayer Aspirin for Children.

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GRIP-TIGHT CAP
for Children's
Greater Protection



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(Continued from page 822)

for ophthalmologists on examination of the eye for possible fitting of contact lenses in Chicago recently. The course is the result of conferences between Dr. Hasty and committees from the National Medical Foundation for Eye Care and from the Section on Ophthalmology of the American Medical Association.

Dr. Lester R. Dragstedt, Research Professor of Surgery at the University of Florida College of Medicine, Gainesville, has received the University of Pennsylvania's 1960 Award for Outstanding Achievement in Surgical Education. The award is presented annually by the Hawthorne Surgical Society of the Graduate School of Medicine at the University of Pennsylvania. Dr. Dragstedt recently was selected as chairman of the Section on Pathology and Physiology of the American Medical Association.

The Seventh Annual Series of Bahamas Conferences which began late in November will be concluded May 6. Five seminars remain to be presented: Conference on Hypertension, January 8-14; Third Serendipity Conference, January 22-28; Second Allergy Conference, February 9-15; Eleventh Medical Conference, April 3-15, and the Conference on Internal Medicine, April 30-May 6. Information and accommodations may be obtained from Bahamas Conferences, P. O. Box 1454, Nassau in the Bahamas.

The University of Miami School of Medicine will sponsor the Third Inter-American Conference on Occupational Medicine and Toxicology in Miami August 6-10, 1961. Dr. M. Eugene Flipse, Professor of Preventive Medicine at the University, is chairman of the program committee. Assisting him is Dr. Joseph R. Vivas, Dean of the University of Puerto Rico School of Medicine.

A meeting of the Neurosurgical Society of America has been scheduled for March 8-11 at Boca Raton, Fla. Dr. Raymond K. Thompson of Baltimore, Md., is secretary.

The American Surgical Association is meeting at the Boca Raton Hotel at Boca Raton, Fla., March 20-24. Dr. John L. Matthews of Jefferson City, Mo., is secretary.

The Gill Memorial Eye, Ear and Throat Hospital will hold its Thirty-Fourth Annual Spring

"...extraordinarily effective diuretic..."[1]

Efficacy and expanding clinical use are making Naturetin the diuretic of choice in edema and hypertension. It maintains a favorable urinary sodium-potassium excretion ratio, retains a balanced electrolyte pattern, and causes a relatively small increase in the urinary pH.[2] More potent than other diuretics, Naturetin usually provides 18-hour diuretic action with just a single 5 mg. tablet per day — economical, once-a-day dosage for the patient. Naturetin c K — for added protection in those special conditions predisposing to hypokalemia and for patients on long-term therapy.

Supplied: Naturetin Tablets, 5 mg., scored, and 2.5 mg. Naturetin c K (5 c 500) Tablets, capsule-shaped, containing 5 mg. benzydroflumethiazide and 500 mg. potassium chloride. Naturetin c K (2.5 c 500) Tablets, capsule-shaped, containing 2.5 mg. benzydroflumethiazide and 500 mg. potassium chloride. For complete information consult package circular or write Professional Service Dept., Squibb, 745 Fifth Avenue, New York 22, N. Y.

References: 1. Dovid, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 2. Ford, R. V.: Current Therap. Res. 2:92 (Mar.) 1960.

Naturetin Naturetin c K SQUIBB

Squibb Benzydroflumethiazide Squibb [illegible] Potassium Chloride



"NATURETIN" & c IS A SQUIBB TRADEMARK.

Congress in Ophthalmology and Otolaryngology and Allied Specialties, April 10 through April 15. There will be twenty guest speakers and fifty lectures. The Congress is scheduled for Roanoke, Va.

The Orange County Heart Association Cardiovascular Seminar will convene February 3 at 8:00 p.m. in the Cherry Plaza Hotel in Orlando with a series of Fireside Conferences. The invited speakers, Drs. Dwight E. Harken and George F. Wilkins of Boston; Dr. Proctor Harvey of Washington, D. C.; Dr. Mason Sones of Cleveland, Ohio; Dr. Freeman Cary of Orlando, and Dr. W. Jape Taylor of Gainesville, will be principal discussers. The following day, the speakers will present addresses, slides and movies of particular diagnostic and therapeutic problems.

Drs. Earl R. Templeton and Norman Jaffee of Miami Beach have been awarded a grant-in-aid for the study of the effects of Mer/29 in arteriosclerotic disease by the research committee of William S. Merrill and Company.

Dr. Benjamin A. Johnson Jr. of Jacksonville has been presented the Hal Davidson Memorial Award for the outstanding paper in 1959 on the subject of pediatric allergy. The presentation took place during the annual meeting of the Southeastern Allergy Association held in Atlanta.

Dr. Robert J. Pfaff of Lakeland attended the postgraduate course in "Upper Extremity Prosthetics" presented at New York University the latter part of October.

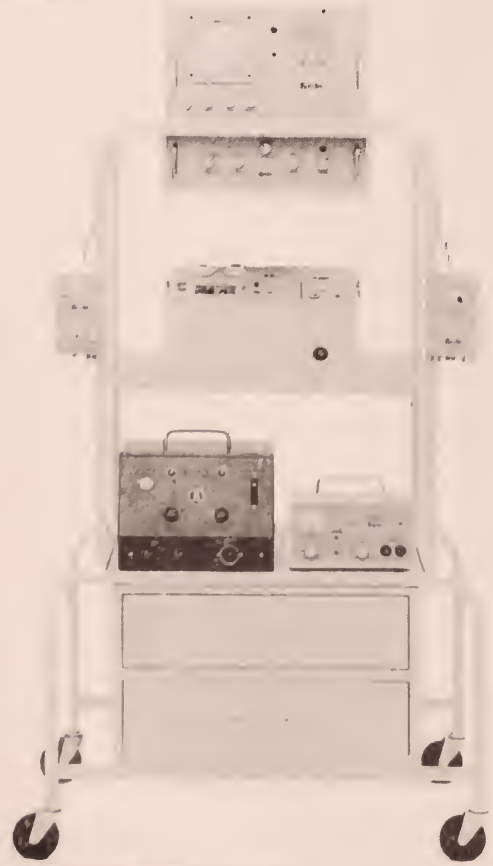
NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Active

Allison, Ronald E., Stuart
Anderson, Raymond T., Coral Gables
Crow, C. Robert, Mount Dora
Dugan, Charles C., West Palm Beach
Ferreri, Salvador, Tampa
Harden, Wyman W., Titusville
Hazen, Olen B., Gainesville
Holmes, Charles M., Miami
Jackson, Andrew R. (Col.), Tampa

(Continued on page 844)



For Prevention and Reversal of

CARDIAC ARREST

*The Birtcher Mobile Cardiac Monitoring and Resuscitation Center**

Cardiac Arrest Is An Ever Present Danger In Anesthesia

Cardiac arrest can occur during any anesthesia, often to patients with no prior record of cardiac disease. Continuous monitoring of every patient can prevent most cardiac arrests by providing advance warning. For cases where the accident cannot be prevented, instruments to reverse the arrest and restore circulation should always be instantly available.

* Comprised of the Birtcher Cardioscope, EEG Pre-Amplifier, Dual Trace Electronic Switch, Electrocardiograph, Defibrillator and Heartpacer with all necessary attachments on a Mobile Stand as shown.

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SPECIFICALLY FOR
INFECTIONS DUE TO
"RESISTANT" STAPHYLOCOCCI

AN ENTIRELY NEW SYNTHETIC
"STAPH-CIDAL" PENICILLIN

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

UNIQUE—BECAUSE IT
RETAINS ANTIBACTERIAL
ACTIVITY IN THE PRESENCE OF
STAPHYLOCOCCAL PENICILLINASES
WHICH INACTIVATE
OTHER PENICILLINS

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NEW SYNTHETIC PENICILLIN FOR "RESISTANT" STAPH

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STAPHCILLIN™

(sodium dimethoxyphenyl penicillin)

For Injection

DESCRIPTION

STAPHCILLIN is a unique new synthetic parenteral penicillin produced by Bristol Laboratories for the specific treatment of staphylococcal infections due to resistant organisms. Its uniqueness resides in its property of resisting inactivation by staphylococcal penicillinase. It is active against strains of staphylococci which are resistant to other penicillins.

Each dry filled vial contains: 1 Gm. STAPHCILLIN (sodium dimethoxyphenyl penicillin), equivalent to 900 mg. dimethoxyphenyl penicillin activity.

INDICATIONS

STAPHCILLIN is recommended as specific therapy only in infections due to strains of staphylococci resistant to other penicillins, e.g.:

Skin and soft tissue infections: cellulitis, wound infections, carbuncles, pyoderma, furunculosis, lymphangitis and lymphadenitis.

Respiratory infections: staphylococcal lobar or bronchopneumonia, and lung abscesses combined with indicated surgical treatment.

Other infections: staphylococcal septicemia, bacteremia, acute or subacute endocarditis, acute osteomyelitis and enterocolitis.

Infections due to penicillin-sensitive staphylococci, streptococci, pneumococci and gonococci should be treated with Syncillin™ or parenteral penicillin G rather than STAPHCILLIN. Treponemal infections should be treated with parenteral penicillin G.

DOSAGE AND ADMINISTRATION

STAPHCILLIN is well tolerated when given by deep intragluteal or intravenous injection.

As is the case with other antibiotics, the duration of therapy should be determined by the clinical and bacteriological response of the patient. Therapy should be continued for at least 48 hours after the patient has become afebrile, asymptomatic and cultures are negative. The usual duration has been 5-7 days.

Intramuscular route: The usual adult dose is 1 Gm. every 4 or 6 hours. Infants' and children's dosage is 25 mg. per Kg. (approximately 12 mg. per pound) every 6 hours.

Intravenous route: 1 Gm. every 6 hours using 50 ml. of sterile saline solution at the rate of 10 ml. per minute.

**Warning:* Solutions of STAPHCILLIN and kanamycin should not be mixed, as they rapidly inactivate each other. Data on the results of mixing STAPHCILLIN with other antibiotics are being accumulated.

DIRECTIONS FOR RECONSTITUTION

Add 1.5 ml. sterile distilled water or normal saline to a 1 Gm. vial and shake vigorously. Withdraw the clear, reconstituted solution (2.0 ml.) into a syringe and inject. The reconstituted solution contains 500 mg. of STAPHCILLIN per ml. Reconstituted solutions are stable for 24 hours under refrigeration.

For intravenous use, dilute the reconstituted dose in 50 ml. of sterile saline and inject at the rate of 10 ml. per minute.

*This statement supersedes that in the Official Package Circulars dated September and/or October, 1960

(continued)

MICROBIOLOGICAL AND PHARMACOLOGICAL PROPERTIES

In vitro studies show that STAPHCILLIN is a bactericidal penicillin with activity against staphylococci resistant to penicillin G. Strains of staphylococci so far tested have been sensitive to STAPHCILLIN *in vitro* at concentrations of 1-6 mcg. per ml. These levels are readily attained in the blood and tissues by administration of STAPHCILLIN at the recommended dosage. This unique attribute is probably due to the fact that STAPHCILLIN is stable in the presence of staphylococcal penicillinase. STAPHCILLIN also resists degradation by *B. cereus* penicillinase. The antimicrobial spectrum of STAPHCILLIN with regard to other microorganisms is qualitatively similar to that of penicillin G; but considerably higher concentrations of STAPHCILLIN are required for bactericidal activity than is the case with penicillin G.

STAPHCILLIN is rapidly absorbed after intramuscular injection. Peak blood levels (6-10 mcg. ml. on the average after a 1.0 Gm. dose) are attained within 1 hour; and then progressively decline to less than 1 mcg. over a 4 to 6 hour period. It is poorly absorbed from the gastrointestinal tract. STAPHCILLIN is rapidly excreted by the kidney.

As shown by animal studies, STAPHCILLIN is readily distributed in body tissues after intramuscular injection. Of the tissues studied, highest concentrations are reached in the kidney, liver, heart and lung in that order; the spleen and muscles show lower concentrations of the antibiotic. STAPHCILLIN diffuses into human pleural and prostatic fluids, but its diffusion into the spinal fluid has not yet been completely studied. However, one patient with meningitis showed a significant concentration in his spinal fluid while on STAPHCILLIN therapy.

Toxicity studies with STAPHCILLIN and penicillin G in animals show that they have approximately the same low order of toxicity.

Certain staphylococci can be made resistant to STAPHCILLIN in the laboratory, but this resistance is not related to their penicillinase production. During the clinical trials, no STAPHCILLIN-resistant strains of staphylococci were observed or developed; the possibility of the emergence of such strains in the clinical setting awaits further observation.

PRECAUTIONS

During the clinical trials, several mild skin reactions, e.g., itching, papular eruption and erythema were observed both during and after discontinuance of STAPHCILLIN therapy. Patients with histories of hay fever, asthma, urticaria and previous sensitivity to penicillin are more likely to react adversely to the penicillins. It is important that the possibility of penicillin anaphylaxis be kept in mind. Epinephrine and the usual adjuvants (antihistamines, corticosteroids) should be available for emergency treatment. Because of the resistance of STAPHCILLIN to destruction by penicillinase, parenteral *B. cereus* penicillinase may not be effective for the treatment of allergic reactions. Information with regard to cross-allergenicity between penicillin G, penicillin V, phenethicillin (Syncillin) and STAPHCILLIN is not available at present. If superinfection due to Gram-negative organisms or fungi occurs during STAPHCILLIN therapy, appropriate measures should be taken.

SUPPLY

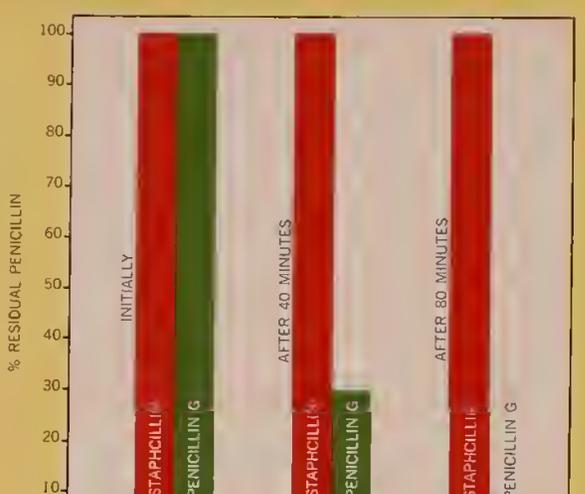
List 79502 — 1.0 Gm. dry filled vial.

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UNIQUE SYNTHETIC "STAPH-CIDAL" PENICILLIN

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In the presence of staphylococcal penicillinase, STAPHCILLIN remained active and retained its antibacterial action. By contrast, penicillin G was rapidly destroyed in the same period of time. *(After Gourevitch et al., to be published)*

Specifically for "resistant" staph...

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

The failure of staphylococcal infections to respond to penicillin therapy is attributed to the penicillin-destroying enzyme, penicillinase, produced by the invading staphylococcus.

Unlike other penicillins:

1 STAPHCILLIN is effective because it retains its antibacterial activity despite the presence of staphylococcal penicillinase.

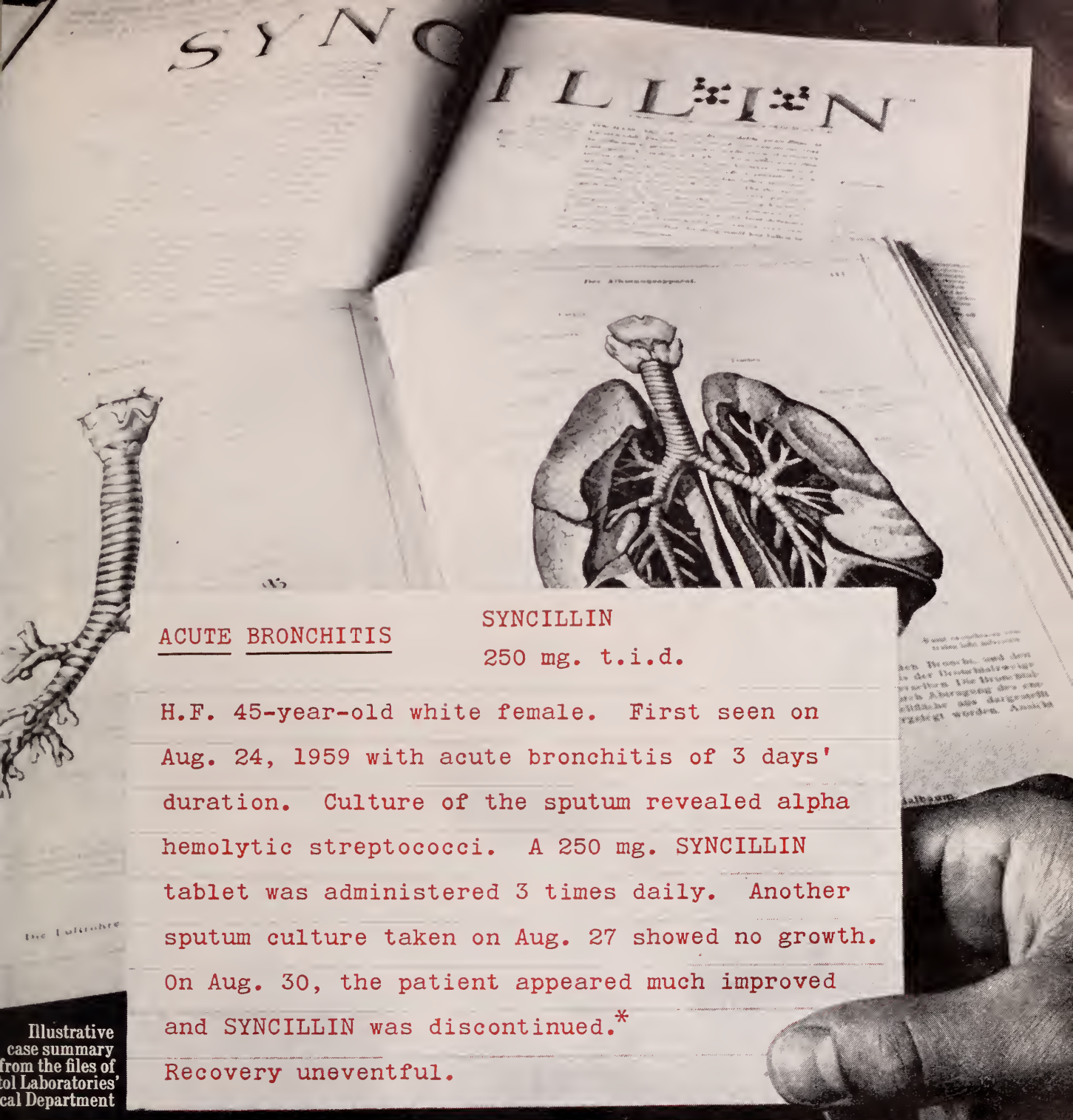
2 The clinical effectiveness of STAPHCILLIN has been confirmed by dramatic results in a wide variety of infections due to "resistant" staphylococci, many of which were serious and life-threatening.

Like other penicillins:

STAPHCILLIN has no significant systemic toxicity. It is well tolerated locally, and pain or irritation at the injection site is comparable to that following the injection of penicillin G. *In occasional cases, typical penicillin reactions may be experienced.*

PROFESSIONAL INFORMATION SERVICE — The attached Official Package Circular provides complete information on the indications, dosage, and precautions for the use of STAPHCILLIN. If you desire additional information concerning clinical experiences with STAPHCILLIN, the Medical Department of Bristol Laboratories is at your service. You may direct your inquiries via collect telephone call to New York, PLaza 7-7061, or by mail to Medical Department, Bristol Laboratories, 630 Fifth Ave., N. Y. 20, N. Y.

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ACUTE BRONCHITIS

SYNCILLIN
250 mg. t.i.d.

H.F. 45-year-old white female. First seen on Aug. 24, 1959 with acute bronchitis of 3 days' duration. Culture of the sputum revealed alpha hemolytic streptococci. A 250 mg. SYNCILLIN tablet was administered 3 times daily. Another sputum culture taken on Aug. 27 showed no growth. On Aug. 30, the patient appeared much improved and SYNCILLIN was discontinued.*

Recovery uneventful.

Illustrative case summary from the files of tol Laboratories' cal Department

THE ORIGINAL phenethicillin

SYNCILLIN®

(phenoxyethyl penicillin potassium)

FIRST SYNTHESIZED AND MADE AVAILABLE BY BRISTOL LABORATORIES

A dosage form to meet the individual requirements of patients of all ages in home, office, clinic, and hospital:
Syncillin Tablets—250 mg. (400,000 units)...Syncillin Tablets—125 mg. (200,000 units)
Syncillin for Oral Solution—60 ml. bottles—when reconstituted, 125 mg. (200,000 units) per 5 ml.
Syncillin Pediatric Drops—1.5 Gm. bottles. Calibrated dropper delivers 125 mg. (200,000 units)

Streptococcal infections should be treated for at least 10 days to prevent the development of rheumatic fever and as prophylaxis against bacterial endocarditis in susceptible patients.

Complete information on indications, dosage and precautions is included in the

BRISTOL LABORATORIES, Div. of Bristol-Myers Co., SYRACUSE, N.Y.

Available only to physicians for their distribution—

Complete Cholesterol Depressant Menus and Recipe Book

A new, authoritative patient-aid . . . for professional distribution only

Now available for use in your practice from The Wesson People . . . easy-to-use manual of 40 pages, including all necessary diet instructions . . . menus, recipes, shopping and cooking guidance . . . all worked out for you . . . so arranged and printed that you have only to check the desired daily calorie level before giving the book to your patient.

You will find this book invaluable for treating patients with elevated serum cholesterol.

Complete menus for 10 days enable you to prescribe diets which are appetizing, nutritiously adequate and which can exert cholesterol depressant activity. Special attention has been given to constructing the menu patterns so that they adhere as closely as permissible to the patient's normal eating habits.

NRC Standards fulfilled. Each menu has been calculated to provide the proper daily allowance of proteins, vitamins and other nutrients as recommended by the Food and Nutrition Board of the National Research Council.

Weight control is achieved as each day's menu is given at 3 calorie levels—1200, 1800 and 2600 calories. You prescribe the level most desirable and modify as desired.

Variety and appetite appeal for patient are built into the menu plan to an extent not previously accomplished. Alternate choices for main dishes minimize monotony, encourage the patient to follow closely the menu plan you specify.

Complete recipes—65 in all—are included to assure that the specified menus provide prescribed levels of calories, the pre-determined ratio of poly-unsaturated to saturated fat, plus essential nutrients.

Dietary fat is controlled so that approximately 36% of the total calories are derived from fat and at least 40% of these fat calories are from poly-unsaturated components (linoleates) as found in pure vegetable oil. The replacement of saturated dietary fat by this percentage of poly-unsaturated fat has been found in clinical studies most effective in the reduction of serum cholesterol and in its maintenance at desirable levels. More liberal menus are provided for maintenance after the patient's progress indicates that desired therapeutic results have been accomplished.

Family meal preparation is simplified. The menus are planned around favorite foods having wide appetite appeal for all members of the household. Patients can entertain in comfort—enjoy cakes, cookies, snacks, prepared with recipes which meet medical requirements.

A high degree of satiety is achieved even at the lower calorie levels, because Wesson provides an unexcelled source of concentrated, slow-burning food energy.

Adaptable for use with diabetics. Carbohydrates have been calculated to fall within the acceptable range for patients to whom a diet planned for diabetes is important. Calories, which must be supplied from fat when the carbohydrate intake is limited, are provided by desirable poly-unsaturated vegetable oil.

WESSON'S IMPORTANT CONSTITUENTS

Wesson is 100% cottonseed oil—winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	16-20%
Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (Predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

Poly-unsaturated Wesson is unsurpassed by any readily available brand, where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen.



USE THIS HANDY ORDER FORM

The Wesson People, 210 Baronne St., New Orleans 12, La.

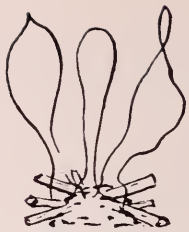
Please send_____free copies of
"Your Cholesterol Depressant Diet Cook Book" for use with patients.

DR._____

ADDRESS_____

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DEFIANT
LONG SMOULDERING
INFECTIONS . . .



OR

ACUTE
CONFLAGRATIONS
OF THE
URINARY TRACT



ALMOST INVARIABLY COOL DOWN
OR ARE SNUFFED OUT WITH

URIPLEX

- Choice for initial therapy of acute urinary tract infections.
- Often effective control for resistant infections of long standing.

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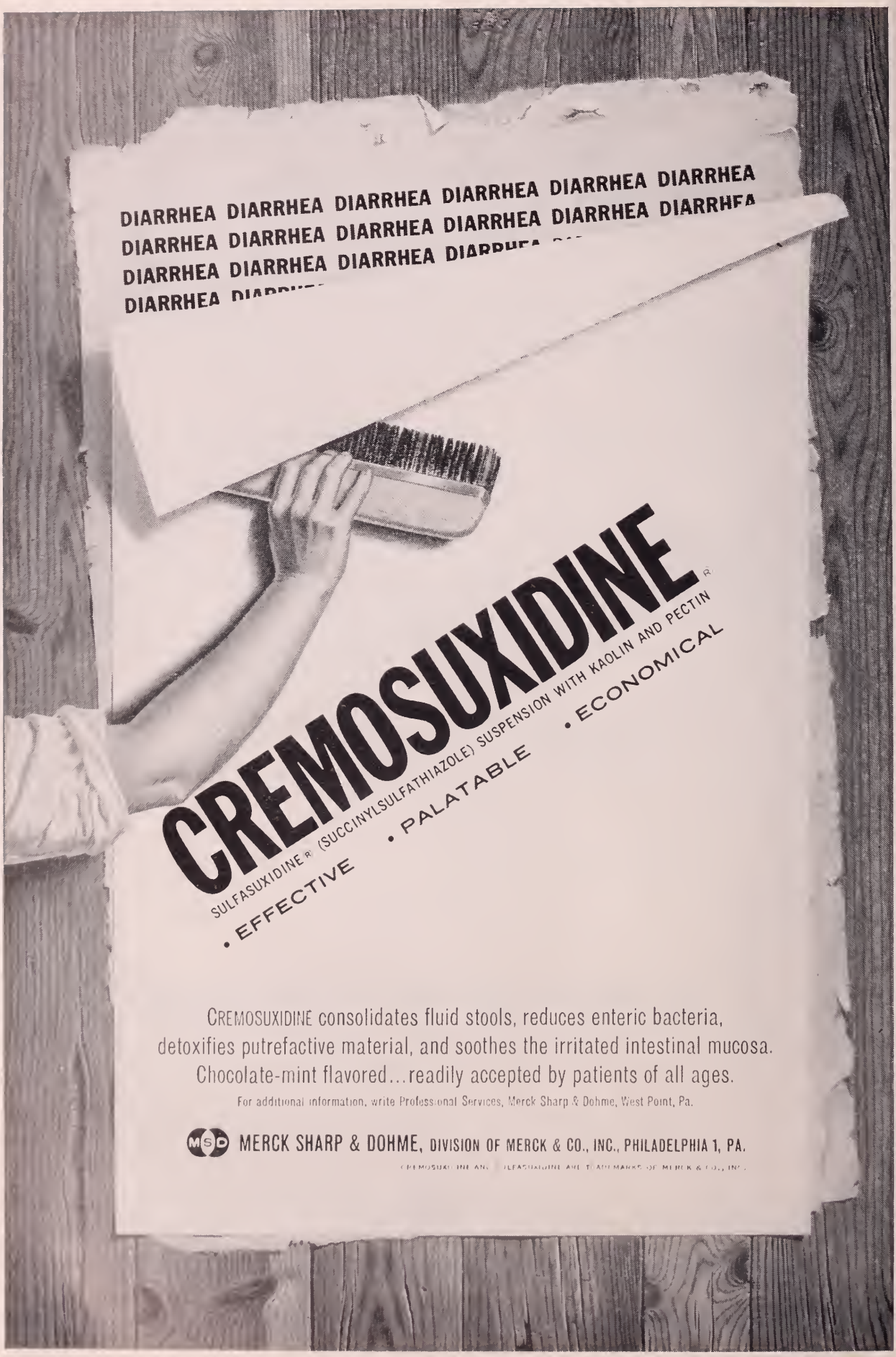
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(1) Bernstein, A. & Simon, F. "The treatment of Obesity in patients with Cardiovascular Diseases" Presented at Am. Coll. of Angiology meeting; June 12, 1960.

(2) Plotz, M.: Modern Management of Obesity, J.A.M.A. 170:1513-1515 (July 25) 1959.

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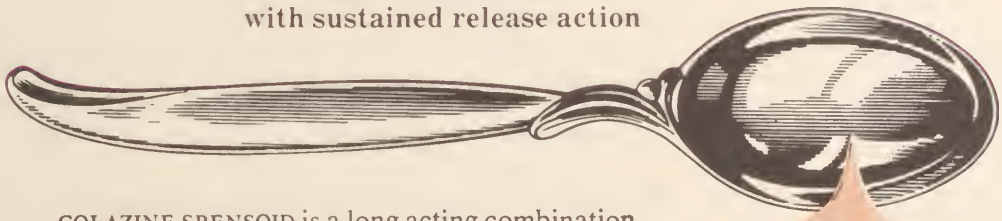
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COMPONENT SOCIETY NOTES

Collier

Dr. William N. Dakos of Birmingham, Ala., was guest speaker at the November meeting of the Collier County Medical Society. He discussed recent advances in the field of otolaryngology.

Lake

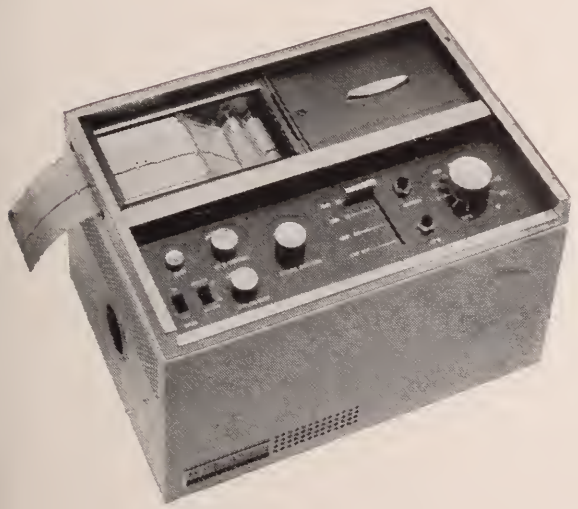
Dr. William Hamm of Atlanta, Ga., was principal speaker at the November meeting of the Lake County Medical Society held at Clermont. His subject was plastic surgery. At the October meeting held at Leesburg, Dr. Henry J. Babers Jr. of Gainesville discussed Blue Shield.

Lee-Hendry

Dr. Jack C. W. Warnock of Fort Myers has been elected president of the Lee-Hendry County Medical Society. Dr. George D. Hopkins II has been chosen to serve with Dr. Warnock as vice president, and Dr. Richard W. Plummer as secretary-treasurer. Drs. Hopkins and Plummer are from Fort Myers.

(Continued on page 856)

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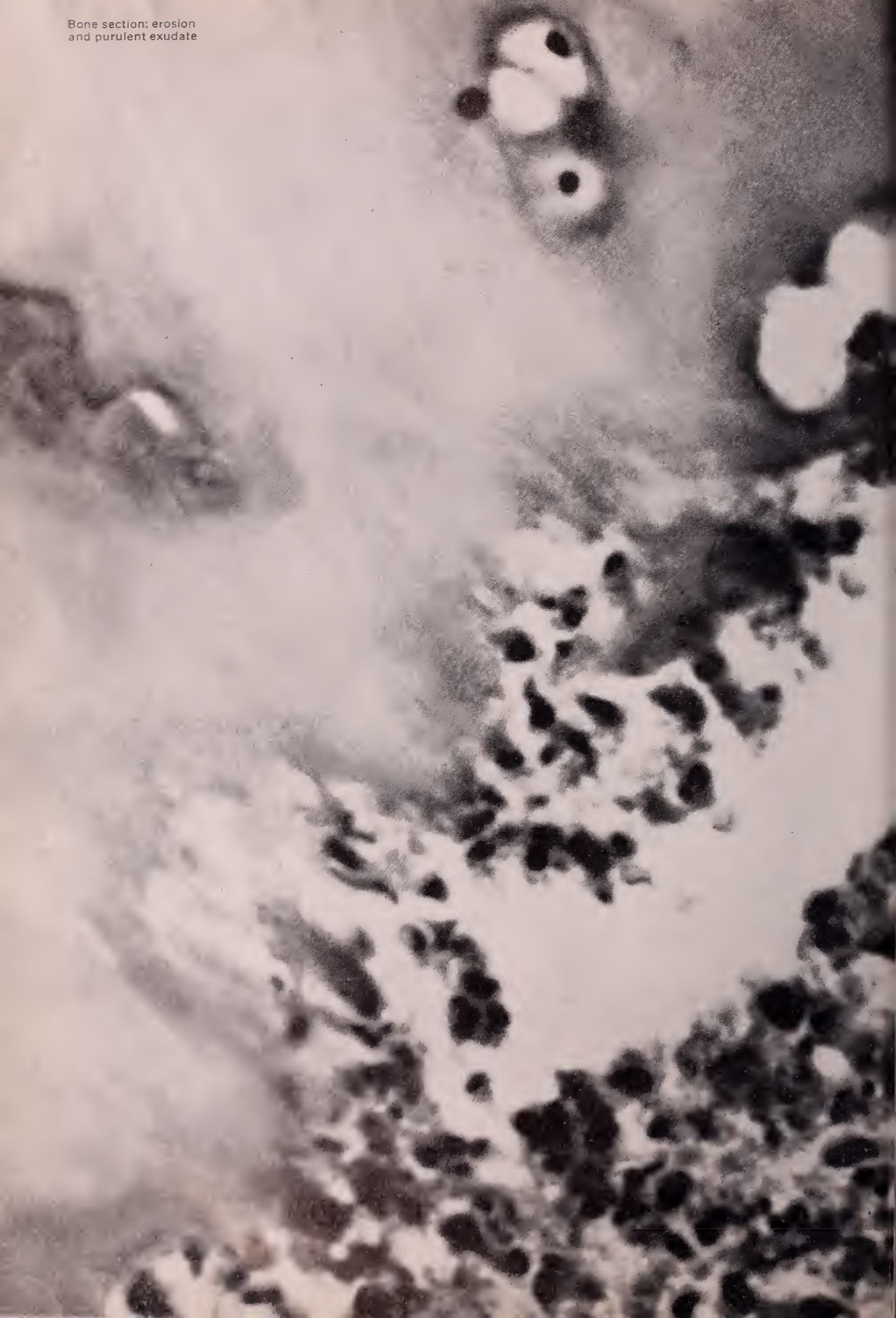
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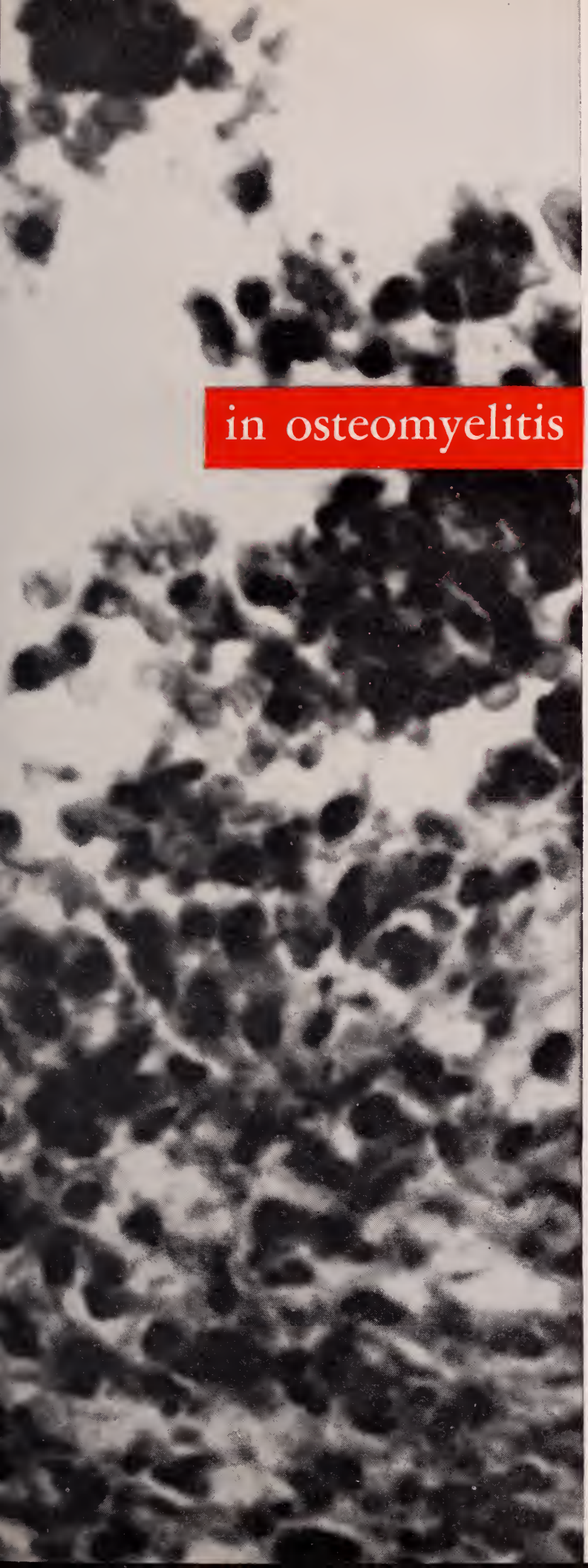
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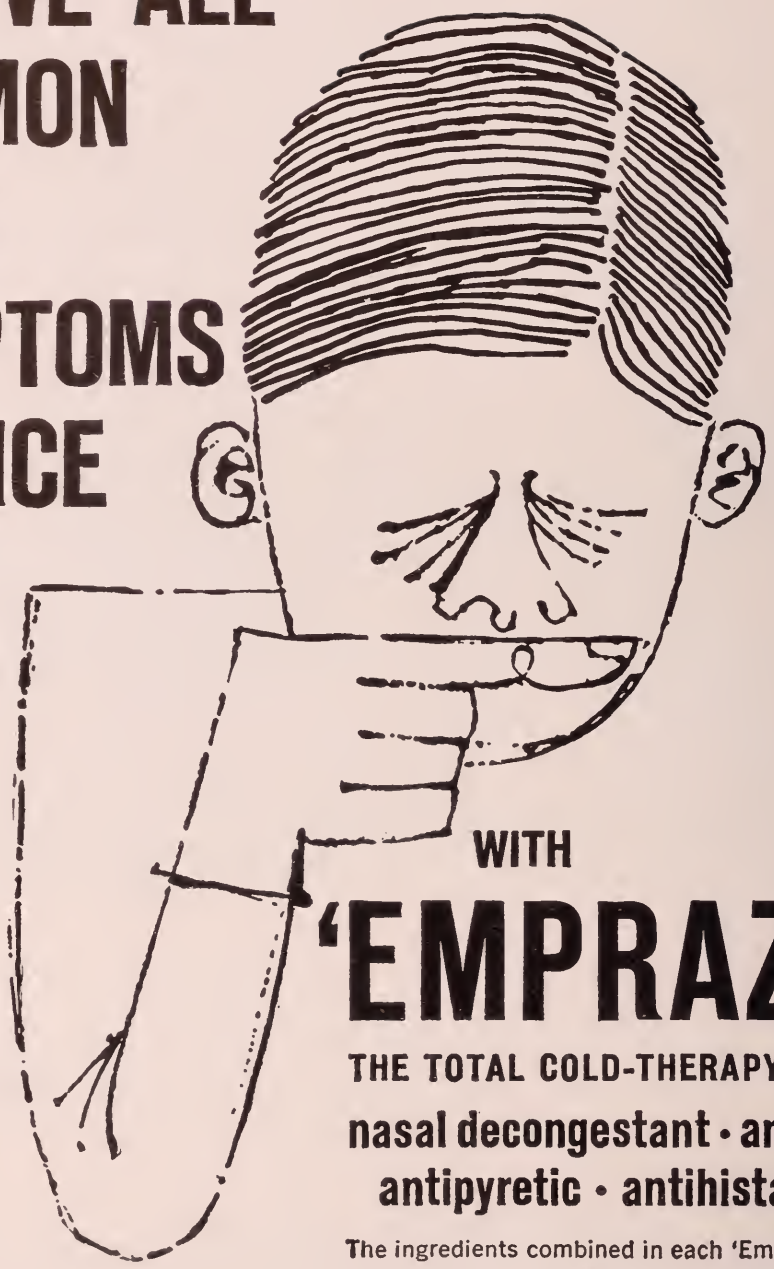
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References: 1. Pitts, R. F., Am. J. Med., 24:745, 1958. 2. Ford, R. V., Cur. Therap. Res., 2:51, 1960.

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1. Weissberg, G.: Clin. Med., June 1960.

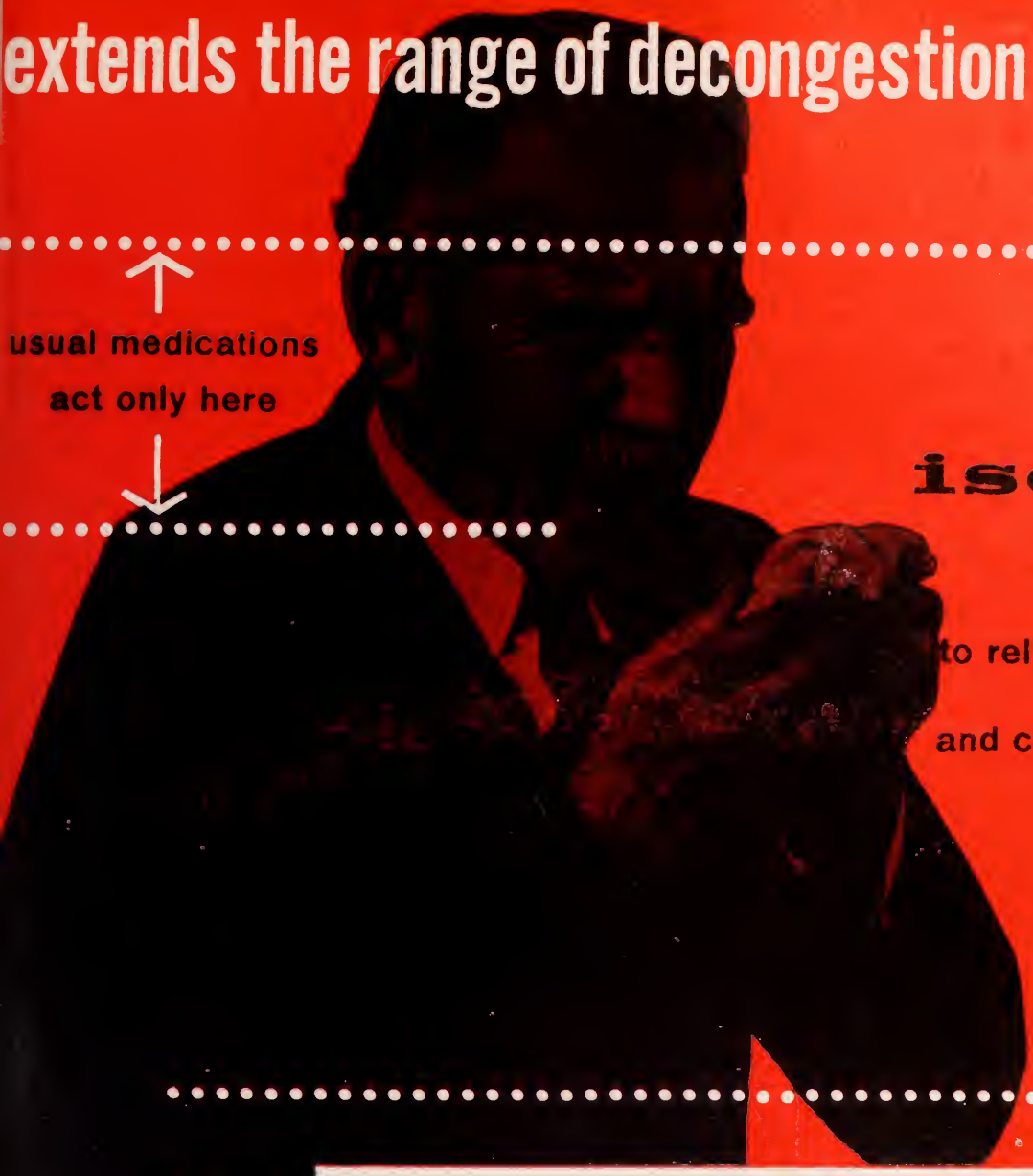
2. Spoor, H. J.: N. Y. St. J. Med., Oct. 15, 1958.

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1. Aviado, D. M. et al: J. Pharmacol. & Exper. Therap. 122: 406-417 (Mar.) 1958. 2. Laboratory Report: Research Div., Chas. C. Haskell & Co., 1959.

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(Continued from page 847)

Jackson-Calhoun

Dr. Terry Bird of Blountstown has been elected president of the Jackson-Calhoun County Medical Society after having served last year as vice president. Dr. Courtland D. Whitaker of Marianna has been chosen vice president, and Dr. Francis M. Watson of Marianna has been re-elected secretary-treasurer.

Manatee

Dr. Warren G. Darty of Palmetto has been installed as president of the Manatee County Medical Society, and Dr. William D. Sugg of Bradenton has been elected president-elect. Other officers chosen at the recent annual meeting include Dr. John A. Shively as vice president, Dr. C. Sumner Quimby as secretary and Dr. Edzell P. Dickerson as treasurer. All are from Bradenton.

Palm Beach

Dr. William H. Proctor of West Palm Beach has assumed the office of president of the Palm Beach County Medical Society. Elected president-elect at the recent annual meeting was Dr. James F. Cooney of West Palm Beach who was treasurer. Other officers include Dr. William H. Everts as vice president, Dr. Herman Baxt as secretary and Dr. Russell D. D. Hoover as treasurer. Dr. Baxt was re-elected.

Sarasota

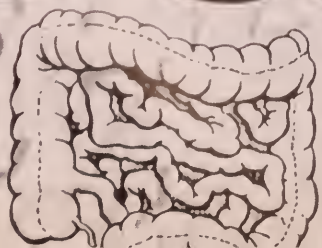
Dr. George A. Bishopric of Sarasota has begun serving as president of the Sarasota County Medical Society. Dr. Harold T. Lawler of Sarasota is the new president-elect. Also elected were Dr. Harry O. Specht Jr. as secretary, and Dr. Millard B. White as treasurer.

Seminole

Dr. Clyde F. B. Smith of Sanford, who served the Seminole County Medical Society last year as vice president, has been elected president. Dr. Charles L. Park Sr. will serve with Dr. Smith as vice president, and Dr. George H. Starke as secretary. Drs. Park and Starke are also from Sanford.

Walton-Okaloosa

Dr. Allen A. Enzor of Crestview has been elected president of the Walton-Okaloosa County Medical Society. Dr. Hiram M. Melvin of Milton has been chosen as vice president; Dr. Albert B. Russell Jr. of Fort Walton Beach as secretary, and Dr. Maxwell G. Carroll of Crestview as treasurer.

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BOOK REVIEWS

Master Your Tensions and Enjoy Living Again. By George S. Stevenson, M.D., and Harry Milt. Pp. 241. Price, $4.95. Englewood Cliffs, N. J., Prentice-Hall, Inc., 1959.

This book provides help wherever one needs it most—on the job, at home, in any of the person-to-person situations one faces daily. It tells exactly what tension is, where it comes from and what one can do to gain release from it. Dr. Stevenson, internationally known mental health consultant and National and International Consultant for the National Association for Mental Health, and Mr. Milt, the Association's Public Relations Director, are admirably qualified to write on the subject. They present eight successful tension-breaking methods: 1. Talk It Out. 2. Escape For Awhile. 3. Take One Thing At A Time. 4. Get Rid Of Your Anger. 5. Curb The Superman Urge. 6. Take A Positive Step Forward. 7. Do Something For Somebody Else. 8. Knock Down The Barbed Wire Fences. The reader learns how to understand himself better, how to avoid tension-building situations and how to overcome successfully the common tensions that plague many people in this "shook-up" age.

The Arterial Wall. Edited by Albert I. Lansing, A.B., Ph.D. Pp. 259. Price, $7.50. Baltimore, The Williams & Wilkins Company, 1959.

A great deal of isolated work on vascular biology has been done throughout the years, but this is the first time that a combined, comprehensive effort has included under one cover a great many aspects of vascular histochemistry, physiology and pathology. Practically every conceivable viewpoint has been touched upon, leading to very interesting thoughts and future challenges. These chapters will help the student, the resident, or the practicing physician realize that the vascular tree is much more than a transport system and, even though there is not a definitive answer to the intimate vascular physiology, a solid bulk of working ideas and facts has been established. The chapters on morphology and physicochemistry have been treated in considerable detail. Extremely interesting is the study of lipid metabolism of connective tissue and its relation to vascular aging in which a very ingenious technique of sponge tissue biopsy is used.

In the whole, this book presents the basic research problems of the vascular system as well as an exhaustive bibliography, both of which show a worth while and brilliant undertaking.

Orlando R. Garcia, M.D.

Clinical Auscultation of the Heart. By Samuel A. Levine, M.D., Sc.D. (Hon.), F.A.C.P., and W. Proctor Harvey, M.D. Ed. 2. Pp. 657. Illus. 660. Price, $11.00. Philadelphia, W. B. Saunders Company, 1959.

Ten years ago the authors first presented this book in an attempt to rekindle interest in cardiac auscultation. It is their thesis that the stethoscope is not generally used with the degree of precision that can be attained with it. The past 10 years have seen an awakened interest in cardiac auscultation with the description of new auscultatory phenomena and better documentation of previously noted phenomena. Thus this second edition is enlarged and more extensively illustrated, particularly as relates to auscultation in the diagnosis of congenital heart disease. Sections deal with the characteristics and genesis of normal heart sounds, cardiac irregularities, cardiac murmurs, and miscellaneous auscultatory findings. In the miscellaneous chapter are sections relating to such things as venous hum, pericardial friction rub, mediastinal emphysema, A-V fistulas, fetal heart sounds, and bruits heard over the neck, eyeball, and skull. For the internist or cardiologist who seeks precision in the use of his stethoscope, this volume is indispensable. All physicians truly interested in diagnosis will find this a lucid, stimulating volume and well worth its price.

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Ciba Foundation Tenth Anniversary Symposium on Significant Trends in Medical Research. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., Cecilia M. O'Connor, B.Sc., and Maeve O'Connor, B.A. Pp. 356. Illus. 41. Price, $9.50. Boston, Little, Brown and Company, 1959.

This is another of the CIBA Foundation volumes which has just been published due to the printer's strike in England last year. It is a special symposium in honor of the tenth anniversary of the CIBA Foundation. Seven of the participants are Nobel laureates. The group of scientists were requested to choose specific trends of the past decade which they thought would prove the most significant in the next decade. This combination of presentations represents studies in the broad spectrum of medical research as it is visualized today. This symposium will fascinate the busy practicing physician while he is on his vacation so that he may return to his office with the feeling that his rest was not a complete medical loss. Each presentation is amazing in itself, but the additional discussion following the delivery of each is superb. The discussers are free to ask or say what they wish, and the informality of the atmosphere is welcoming. Though one may think the circumference of this "round table" affair is too vast to be chained, the reader is dazzled as he follows the sequence of regular connected links from molecular structure to the quantitative approach to disease. While delving through this intoxicating volume he will feel that he has ascended into the sky and is being exposed to the universal field of medicine! This is a must for the physician's library.

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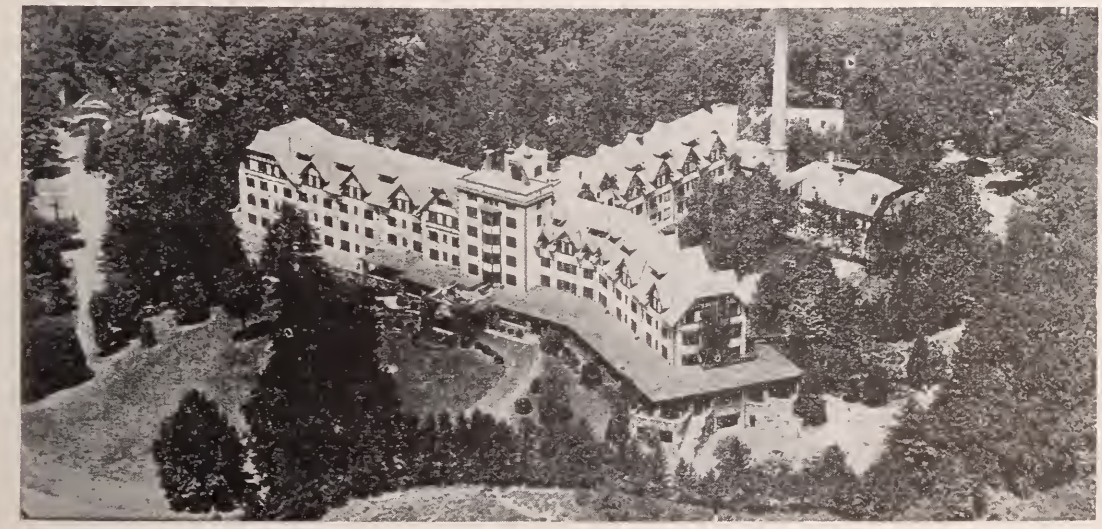
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* *Bradford, Gilchrist, Union*					
Bay	John J. Hollomon, Panama City	A. Ralph Monaco, Panama City	2nd Tues.		33
Brevard	Willard H. Bennett, Titusville	Frederick H. Lucas, Cocoa Beach	1st Tues.	2	74
Broward	Burns A. Dobbins Jr., Ft. Lauderdale	Frederick W. Fisher, Ft. Lauderdale	4th Tues.	42	267
Charlotte	Carl N. Reilly, Punta Gorda	Stephen R. Roddy, Punta Gorda	2nd Tues.		7
Collier	Loral F. Gwaltney, Naples	Ethel H. Trygstad, Naples	4th Tues.		14
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.		12
* *Baker*					
Dade	Willard L. Fitzgerald, Miami	George W. Robertson III, Miami	1st Tues.	132	1048
DeSoto-Hardee-Glades	Harold S. Agnew, Arcadia	Elmer J. Schmierer, Arcadia	1st Tues.		14
Duval	Sidney Stillman, Jacksonville	Robert J. Brown, Jacksonville	1st Tues.	5	357
Clay	Marcus B. Bergh, Orange Park	John M. Malone, Green Cove Springs			10
Escambia	P. G. Batson Jr., Pensacola	Vernon L. Smith, Pensacola	2nd Tues.	1	119
Franklin-Gulf	William F. Wager, Port St. Joe	Henry I. Langston, Apalachicola	Last Wed.		7
Highlands	Hubert W. Coleman, Avon Park	Samuel A. King, Avon Park	3rd Mon.	1	12
Hillsborough	Herbert B. Lott, Tampa	Frank A. Massari, Tampa	1st Tues.	2	264
Indian River	Phil D. Morgan, Vero Beach	Walter W. McCorkle, Vero Beach	2nd Tues.	2	14
Jackson-Calhoun	Terry Bird, Blountstown	Francis M. Watson, Marianna	Quarterly		17
Lake	Lawton F. Douglass, Umatilla	Raymond A. Debo, Eustis	1st Wed.	4	35
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Pasco-Hernando-Citrus	William H. Walters Jr., Lacoochee	W. Wardlaw Jones, Dade City	2nd Thurs.	1	21
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Suwannee-Hamilton-Lafayette	Frederick T. Mickler Jr., Jasper	Irby H. Black, Live Oak	1st Sat.		7
Taylor	John A. Dyal Jr., Perry	Charles M. Roberts, Haines City	Last Fri.		5
* *Dixie*					
Volusia	C. Robert DeArmas, Daytona Beach	Thomas W. Ayres, Daytona Beach	2nd Tues.	6	99
* *Flagler*					
Walton-Okaloosa-Santa Rosa	Allen A. Enzor, Crestview	Albert B. Russell Jr., Ft. Walton Beach	3rd Tues.	4	33
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay	Quarterly	3	4
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Source: Harrison, T. R., *et al.:* Principles of Internal Medicine, ed. 3, New York, McGraw-Hill Book Co., 1958, p. 620.

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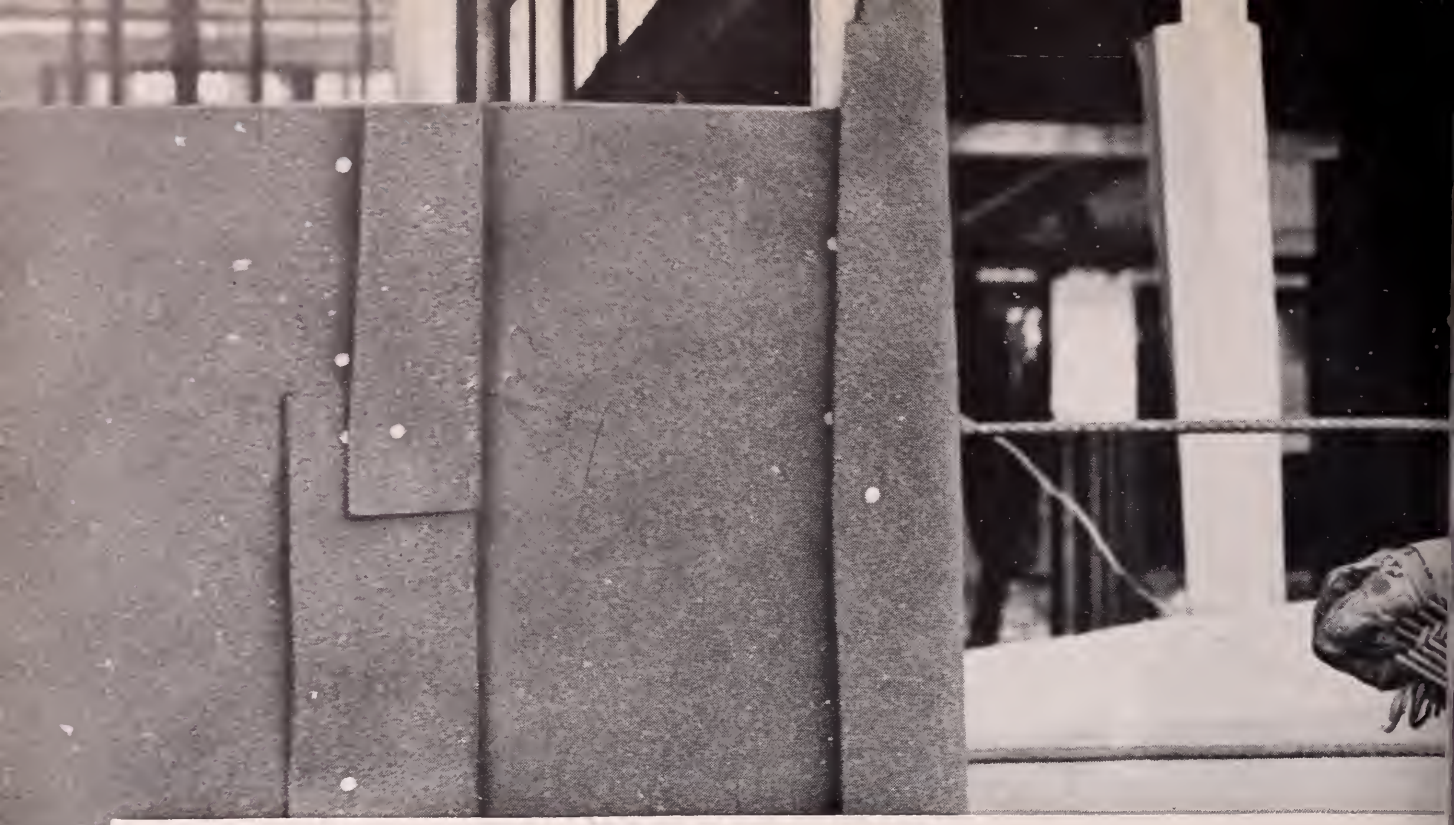
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VOLUME XLVII, No. 8

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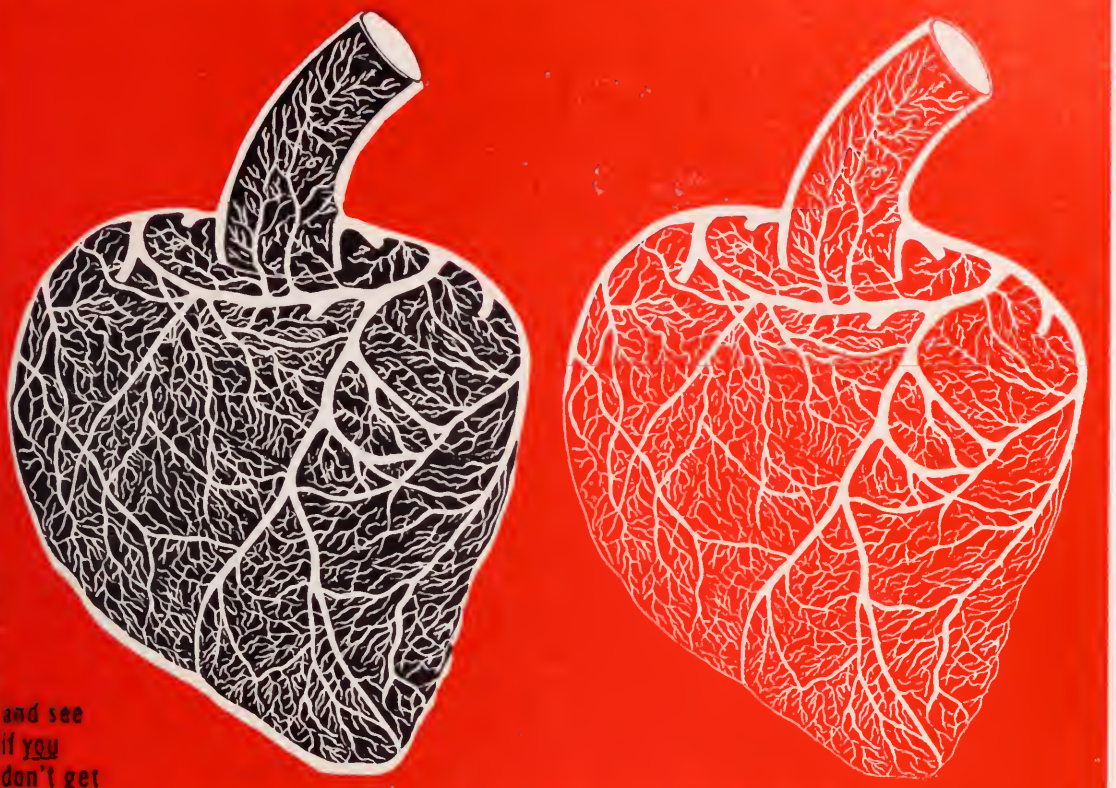
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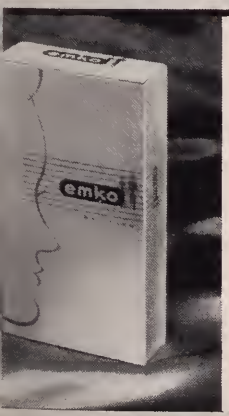
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REFERENCES:
(1) Buck, R. C.: Minerals of Normal and Arteriosclerotic Aortas, Arch. Path., 51, 1951. (2) N. Ressler, et al.: Relation of Serum Stability to the Development of Arteriosclerosis, Amer. J. Clin. Path. vol. 24, 1954. (3) S. D. Jacobson, M.D., Wayne County General Hospital, Eloise, Michigan. To be published. (4) Prof. V. Patzelt, Untersuchungen uber die Veranderunger der Bluteiweisz-Korper mit Mag. 3, 7-dimethyl-xanthine oleate, Klin. Med. 5, 11, 1956. (5) Dr. J. Skursky, Wiener Med. Wochenschrift, 1953, Nr 46, S. 886-887. (6) Eduard Keeser, M.D. and K. F. Benitz, M. D., Med. Klin. 1953 Nr. 15.

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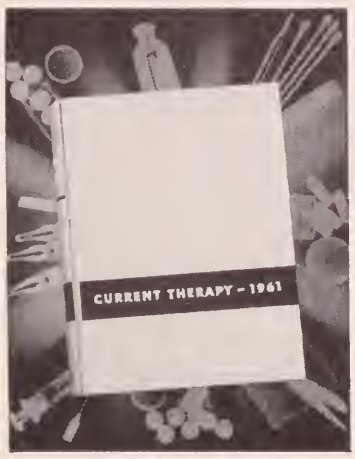
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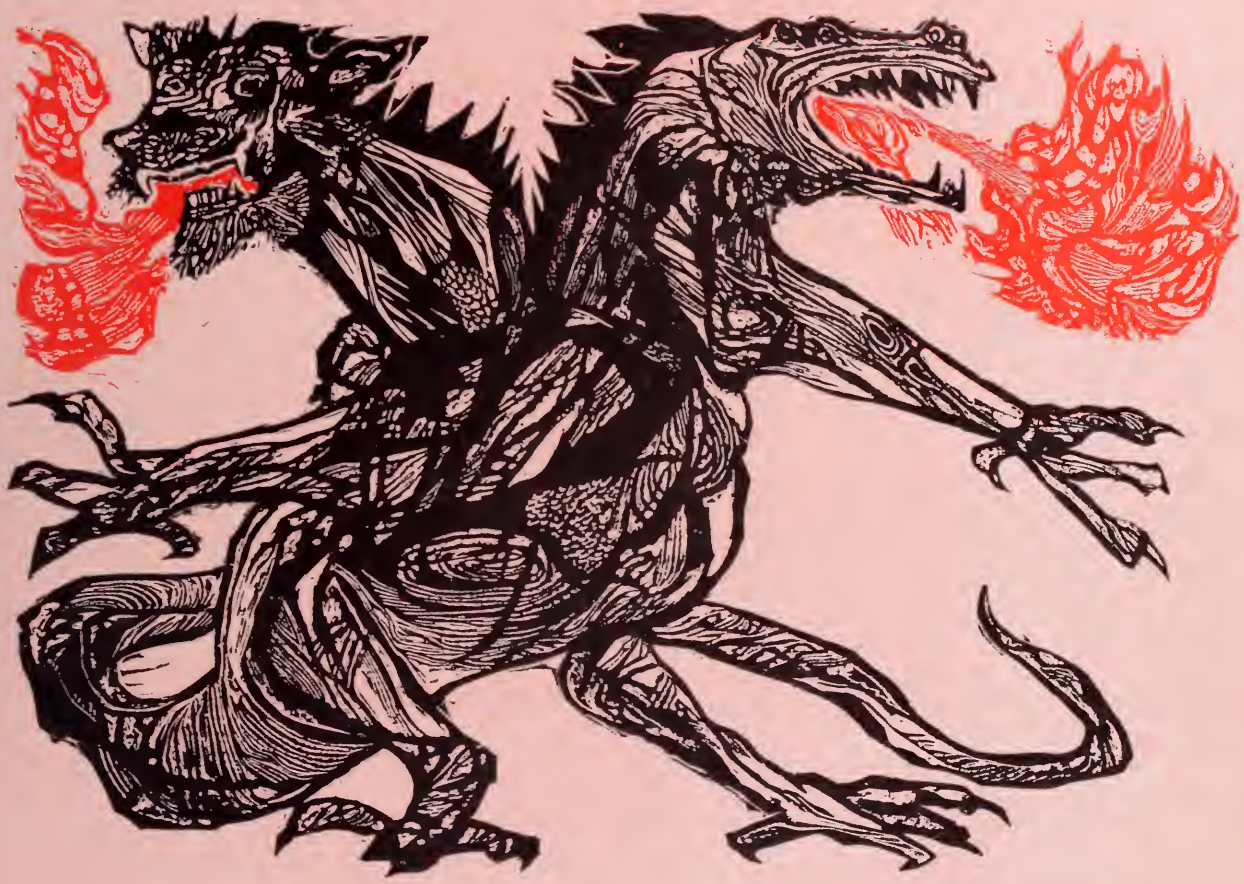
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Teamwork in Massive Peptic Ulcer Bleeding

Analysis of Thirty-Four Cases of Peptic Ulcer Deaths

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The purpose of this study is to present the multiple-faceted problems in the management of patients with bleeding peptic ulcer and to show that the management is largely one of careful individualization, taxing the utmost skill of the physician. It is difficult to ascertain the primary factor or factors leading to the demise of these patients, but within the limits of our shortcomings, we present our evaluation of 34 cases in which the patient died. The ulcer as the site of bleeding was confirmed by surgery or autopsy. These cases were taken from the records of Jacksonville hospitals for 1955-1959. It goes without saying that a hindsight analysis is much clearer than a prospective one; nevertheless, as best we could learn from attendance at actual necropsy conferences of the cases studied, from talking with the doctors involved, and from careful retrospective appraisal of the charts of the 34 patients, we have attempted to show the highlights of management and the numerous "Pilgrim's Progress" pitfalls along the way. This type of Monday morning quarterbacking may not win the next encounter, but the chase may be more intriguing.

We would like to review briefly the problems of massively bleeding peptic ulcers. Certainly the confusion is exemplified by the diversity of therapy, ranging from the studied neglect feeding regimens of Andresen[1] to the early surgical-minded programs of Stewart and his associates.[2] Most modalities of therapy have been attempts at oversimplification, but we believe the factors are so variable and numerous that we find ourselves preferring the strict individualization of patients.[3]

In choosing to discuss bleeding peptic ulcer instead of all massive upper gastrointestinal bleeding, we are confronted with the problem of differential diagnosis, which is not to be minimized. Most of the evidence today points to the fact that 70 to 85 per cent of upper gastrointestinal bleeding stems from peptic ulceration. The over-all medical mortality is approximately 15 per cent,[4] notwithstanding the fact that an honest statistician with a mild prejudice can cause the percentage to vary widely. The second largest group stems from esophageal varices, this condition accounting for 10 to 25 per cent[4,5] of upper gastrointestinal bleeding. The usual medical mortality for bleeding varices is extremely high, being in the neighborhood of 30 to 50 per cent; the surgical mortality equals this. The group to be salvaged is that of bleeding peptic ulcer. A bleeding esophageal lesion, when operated on from below, can be sutured about as well from that position by using sternal splitting as it can through a thoracotomy approach and with about the same mortality. Differential diagnosis between these two lesions, varices and ulcer, when coupled with an adequate history, physical examination and proper laboratory procedures is not a tremendous problem. If, however, the diagnosis is obviously esophageal bleeding from varices, we prefer the

Study under Jacksonville Hospitals Education Program, Gastrointestinal Clinic, Duval Medical Center, Jacksonville.
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balloon tube to operation. Peptic ulcer and cirrhosis occur together frequently enough to warn against forgetting one in the face of the other. One final word about diagnosis: to kill the patient making a diagnosis is, as the British would say, "less than desirable." As difficult as the diagnosis may be, the greater problem is management, and we have analysed these deaths largely from that viewpoint.

The definition of massive hemorrhage varies widely. Stewart and his associates,[2] on the basis of blood volume studies, defined loss of 40 per cent of the red cell mass (hemoglobin 8 Gm.) and evidence of 500 cc. of blood loss in the past week as their definition. Welch,[4] emphasizing without blood volume determination, defined massive hemorrhage as a decrease in hemoglobin to 7 Gm. or less, and a need for five or more transfusions. Others defined (1) a fall in blood pressure of 50 points; (2) three tarry stools in 12 hours; (3) hematemesis of 1 pint; and (4) a fall in red blood cells below three million. The universal adoption of Stewart's or Welch's definition would serve as an effective guide for therapy.

THE PRESENTING EVALUATION OF THE PATIENT.—We found that in 19 of the cases studied the patient arrived with presenting complaints of hematemesis and melena of only one day's duration or less; in the remainder there was a history of bleeding from two days to two weeks (table 1). Twelve patients were in shock; all had hematemesis except two, and all had melena. All of this information is of significance in that it points out that the exsanguination leading to the ultimate demise of this group of patients stemmed from a clear break in the wall of a moderately large vessel and was arterial in nature. Less than one third (10) of these patients had a history of previous bleeding, a finding pointing vividly to the conclusion that fatal massive ulcer bleeding often comes as the first episode.[6] It is noteworthy that a documented ulcer history was given in only two thirds of these 34 cases studied.

AGE, SEX AND ASSOCIATED DISEASE. — As would be expected, age and associated disease ran hand in hand; most of the deaths occurred in the older age group, the age of the youngest being seven weeks and of the oldest 84 years (table 2). Only four patients were under 40 years of age. Seventy-seven per cent (26 patients) were over the age of 50. Sixty per cent (20 patients) had cardiovascular disease (table 3). Only four patients (the younger group) had no associated disease. Four had pulmonary complications and, unlike in all of the cardiovascular cases, the deaths were directly correlated with these complications. Pulmonary emphysema is a very hazardous associated disease in this type of patient. Cole and his associates[7] reported that the mortality rate for surgery is four times greater in the older age groups than in younger patients subjected to the same operation. Age is a most important factor and because of the narrow reserve limit imposed by it, earlier surgical intervention in the elderly is more justified than in the younger group. There were 26 (three fourths) males, as compared to

Table 1. — The Presenting Evaluation of Thirty-Four Cases of Peptic Ulcer Deaths

Onset Days Prior to Admission	Surgical Cases	Medical Cases	Total Cases
1	13	6	19
2	1	2	3
3	4	3	7
4 — over	2	3	5
Past history of massive bleeding	6	4	10
Past ulcer history	13	7	20
Shock on admission or shortly thereafter	7	5	12
Hematemesis on admission	19	13	32
Melena	20	14	34

Table 2. — Age

Years	Patients	
0 - 20	1	(7 weeks)
21 - 40	3	
41 - 50	4	
51 - 60	5	
61 - 70	9	77%
71 - 80	9	
80 - 90	3	

Table 3. — Associated Diseases

Cardiovascular disease	19
Pulmonary disease	4
Hepatic disease	3
Renal disease	1
Others	2
None	5

Table 4. — Sex

Males		26
Gastric ulcer	8	
Age 60 and over	7	
Females		8
Gastric ulcer	1	
Age 42		

Table 5. — Site of Ulcer

Posterior penetrating duodenal ulcers	18
Gastric ulcers	9
Postbulbar duodenal ulcers	4
Marginal ulcers	2
Multiple acute ulcers (erosions)	1

Table 6. — Rate and Duration of Bleeding

	20 Surgical Cases	14 Medical Cases
Rate of bleeding 1 pt./8 hrs. (very important factor)	13	3
Inadequate transfusions (in 8 an important factor)	15	13
Hours after admission to operation or medical demise	9 < 24 hrs. 4 < 48 hrs. 7 > 48 hrs.	8 < 48 hrs. 6 > 48 hrs.
Delay of surgeon seeing patient (in 8 an important factor)	13 < 12 hrs. 7 > 12 hrs.	3 < 12 hrs. 5 > 12 hrs. 6 not seen
Continuous bleeding	6	6
Recurrence of bleeding on conservative treatment	13	6

eight females, reflecting the usual sex distribution of peptic ulcer (table 4).

Any type of management in these elderly patients is hazardous, and the less stress placed on the organism the better. Individualization is the keynote.

Site of the Ulcer.—As alluded to earlier, massive bleeding from peptic ulcers stems from erosion into large vessels. Over one half of the ulcers in this series were of the posterior penetrating variety with the ulcer eroding into some branch of the gastroduodenal artery (table 5). Nine gastric ulcers occurred, and all but two were in patients over 60 years of age. Surprisingly, eight of these gastric ulcers were in males. There were four postbulbar duodenal ulcers in this group. It is common knowledge that bleeding gastric and postbulbar duodenal ulcers are especially difficult to manage by conservative means.

Factors of Interim Management

Rate and Duration of Bleeding.—The rate of bleeding, as Hoerr, Dunphy and Gray[8] stated, is a decisive factor, and one of the most important. Of the 20 patients operated upon, 13 were losing more than 1 pint of blood every eight hours, as were three medically treated patients (table 6). Of equal importance to rate is inadequate transfusion of the patient, as was exhibited in 15 surgically treated patients and 13 medically treated patients. We believe that the rate of loss is of primary importance, for if it is so rapid as to require 1 pint of blood per eight hour period, there is less likelihood that conservative therapy will be effective. One should realize that blood given to bring the admission hemoglobin level of 7 Gm., for example, to 13 or 14 Gm. must not be counted as blood given for the control of bleeding, but rather as replacement of physiologic blood volume. It has been the contention of many,[3] and we agree, that the blood volume must be replaced as soon as possible. During the first 24 hours, we like to determine hemoglobin and hematocrit levels every four to eight hours and judge from them, along with associated clinical signs such as blood pressure, pulse and general appearance, as to whether the lesion continues to bleed. It is important to note and record the number of times the patient vomits blood, as well as the frequency of tarry stools, for when a patient passes frequent bright red stools, he is bleeding severely.

Timing of Surgical Intervention. — Although most of the patients (9) in this series were operated on within the first 24 hours, it is our opinion that this time might be better spent evaluating the patient's rate of blood loss and restoring his blood volume to normal. In some patients the bleeding is so rapid that surgical intervention must be initiated within the first 24 hours; these are exsanguinating patients. Fifteen of the patients were subjected to operation with inadequate blood replacement; perhaps with more intensive presurgical management, these patients would have been better candidates for operation in the second 24 hour period. It is our belief that inadequate blood replacement can be judged fairly accurately by correlation of the vital signs, frequent determination of hemoglobin and hematocrit levels and the amount of blood administered. Utilizing these data, we noted that in 12 cases there was continuous bleeding, in some instances mild and in some severe. We classified as severe the loss of more than 3 pints of blood in the first 24 hours. Six other patients with continuous bleeding who were surgically treated were inadequately transfused. Patients in whom bleeding recurs, like those in whom it is continuous, present a difficult problem. There was recurrence of bleeding in 19 patients, 13 treated surgically and six medically; these patients were on adequate medical management when the bleeding recurred (table 7). Recurrence of bleeding warrants surgical intervention because of the continuing activation of the ulcer, the impaired vascular contractility and the necessity for ligature control of the bleeding vessel.

This continuous or repeated bleeding from the gastroduodenal vessel brings to mind LeVeen's interesting experiment which showed conclusively that the hepatic system does not tolerate blood loss as well as does an extremity.[15] Bleeding peptic ulcers drain the liver directly through the he-

Table 7. — Timing of Surgical Intervention

	20 Surgical	14 Medical
Hours after admission to operation or medical demise	9 < 24 hrs. 4 < 48 hrs. 7 > 48 hrs.	8 < 48 hrs. 6 > 48 hrs.
Delay of surgeon seeing patient (in 8 an important factor)	13 < 12 hrs. 7 > 12 hrs.	3 < 12 hrs. 5 > 12 hrs. 6 not seen
Continuous bleeding	6	6
Recurrence of bleeding on conservative treatment	13	6

patic and gastric vessels, causing hepatic anoxemia. Prevention of the resulting hepatic insufficiency is an indication for earlier surgical intervention. The peripheral blood pressure may be maintained at respectable levels, yet the hepatic pressure may be low, particularly in patients with continuous bleeding. During this time when one is trying to decide whether surgical intervention is necessary, therapy must be vigorous and intensive, with constant visits to the patient's bedside.[9] If a patient continues to lose more than 1 pint of blood every eight hours within the first 24 hour period, that is, more than 1,500 cc. after the initial blood volume replacement, he should be operated on. In over half (8) of the medical cases the patient died within the first 48 hour period, and although this outcome to a large extent is a reflection of inadequate transfusion, we believe that it brings up the point of recognition of a "point of no return."

TEAMWORK.—That a patient with massive bleeding be seen from the outset by both internist and surgeon is to us no more than common sense. Both of these physicians have a well disciplined knowledge of contemporary homeostatic mechanisms which could be advantageously incorporated by both. A case in point is one in which a period of 90 hours elapsed before the surgeon was called and only three pints of blood had been given prior to the surgical consultation. A consultation from the outset would have intensified the therapy, another opinion would have been given, and the patient would not have continually lapsed in and out of shock prior to operation. The very fact that when the series is viewed retrospectively, there were four medically treated patients who should have been operated on and three surgically treated patients who should have had medical care is proof that a joint consultation is necessary. We thought that eight patients would have benefited through closer liaison. That intangible factor known as "getting the feel of the patient" is most important, both for the internist and the surgeon. One of the eight patients who died was overtransfused in the operating room and undertransfused preoperatively. At autopsy, pulmonary edema was present. Had the surgeon "had the feel of the patient," we believe that the demise would have been obviated.

There was another case in which the operation began two hours after the surgeon saw the patient, and retrospectively the patient's deteriorating condition was due to a coronary condition. One patient was greatly undertransfused, and apparently the surgeon was not aware of this fact. In three cases the internists held on to patients in spite of surgical consultations urging surgical intervention; this attitude speaks for lack of close cooperation. It is our opinion that in the management of this problem, there is no place for medicosurgical rivalry. The spirit of cooperation should prevail. The ulcer does not know whether it is being treated by a surgeon or an internist. The surgeon should realize that the bleeding from a peptic ulcer is not like the bleeding from a fractured spleen;[10] as we know from clinical experience, in many instances the latter will stop and will not require surgical intervention. Saltzstein and his associates[11] in their assay of the situation showed that about 80 per cent could be handled well without surgical measures, whereas about 20 per cent would be treated better by surgical means. The difficulty, of course, arises in the placing of each in its proper perspective and category. In only 16 of the cases did the surgeon see the patient before 12 hours had elapsed. The patient was not seen by a surgeon at all in six cases; the seeing of the patient by the surgeon was important in eight of the 34 cases. No other means except careful individualization by the surgeon and the internist, with each seeing the patient from the outset, can effectively accomplish the proper assorting and better therapy.

INADEQUATE TRANSFUSIONS. — Inadequate transfusion was the most important factor in the demise of these patients, being of primary importance in 28 of the 34 cases. It is of interest that in over half of the medical cases (9) the patient received five pints of blood or under during the period of therapy (table 8). This amount certainly reflects inadequate transfusion in these patients, since the hemoglobin was cut in half (7 to 8 Gms.) in this group. The surgical patients received much more blood than did the medical patients, 14 receiving 11 pints or more.

Table 8. — Amount of Blood Given

Pints	Prior to Operation Cases	During Operation Cases	Total Pints of Blood Medical	Surgical
Under 5	4	13	9	0
6 - 10	13	4	2	6
11 - 20	3	3	2	12
21 - 30			0	2
Over 30			1	0

(Only one transfusion reaction)

Table 9. — Operative Factors

		Surgical
Bleeding of the ulcer site at time of operation		14
Operative time (decisive in 4 cases)	3 < 2 hrs.	
	13 < 4 hrs.	
	4 > 4 hrs.	

This difference may indicate that the surgical patients experienced more severe bleeding than the medical ones; tempering this conclusion is the fact that several of the surgical patients (6) had excessive blood loss at operation. This group of patients received a tremendous amount of blood, and we were surprised to note the paucity of findings in the charts which would incriminate blood transfusion reactions. In only one case did such a reaction seem to be of paramount importance. Since many of these patients died of conditions which may have masked a transfusion reaction or may have caused it to play an inconsequential part in the evaluation of the demise, we can draw no safe conclusions of the blood transfusion reaction rate in this group.

Massive blood replacement, while necessary, does carry risks. All are familiar with post-transfusion hepatitis, citrate intoxication, transfusion reactions and the like. These must be watched for, but in no way are a deterrent to administration of large amounts of blood. The so-called bleeding tendency due to transfusions may be of multiple origin—platelet dilution, afibrinogenemia, loss of labile factors of clotting. It is often found that 3 or 4 pints of blood may produce these aberrations of bleeding. Krevans[9] found that in all of 14 patients receiving 10 pints of blood and over, there was a thrombocytopenia and most had an abnormal bleeding tendency.

Operative Factors Influencing Management

Actual bleeding from the ulcer site at the time of the operative procedure did not seem to be a great factor in the management of these patients. In 14 of the 20 surgically treated patients there was bleeding at the time of operation (table 9). It is our belief that this finding is not paramount provided, of course, that the patient was bleeding, or there was presumptive evidence of continued or recurrent bleeding at the time of surgical decision. Finding active bleeding lends confidence to the surgeon that the bleeding site has been found.

Similarly, operative time did not seem to be a great factor in the demise of these patients. Most of them (13) required less than four hours of operative time. There were, however, four patients who had, in our opinion, too large a procedure, as exemplified by too much operative time.

More and more thought is being given to the operative procedure itself as a major factor in the cause of the demise of these patients. In the acutely ill, the less the procedure the less stress on the organism. Simple ligature of the vessel has been in disfavor because it has been claimed that it will not adequately protect the patient against bleeding in the postoperative period.[3] The location of the ulcer and the condition of the tissues might make this simple procedure less than desirable. In one of the cases presented, the ulcer had previously been sutured and a gastrojejunostomy of the Billroth II type was carried out. The patient, after receiving 8 pints of blood, expired 63 hours after the operation from postoperative hemorrhage attributed to the previously ligated ulcer bed. This patient had cirrhosis and obviously this was a factor in the fatal hemorrhage. In another case a 64 year old man with a marginal bleeding ulcer of the Billroth I type was dangerously and laboriously carried through an operation lasting seven hours with the loss of 7 pints of blood during the procedure; this patient expired four days later with pancreatitis (amylase 1,050 SU). Clearly, this was an error in judgment on the part of the surgeon. We think that, while removal of the ulcer is ideal, many of these patients cannot tolerate large procedures of a great definitive nature. In some cases simple ligature of the vessel may suffice;[12] in others a pyloroplasty and vagotomy as advocated by Westland, Movius and Weinberg[13] may be sufficient. A blind resection[5] is in order when no specific site of the gastric bleeding is found, but not until a thorough search of the stomach and duodenum has been made. Individualization tempered with sound judgment is a doctrine of management at the operating table, as well as in the preliminary phases.

Other than too large a procedure, errors of surgical therapy are errors of technique as well

as blood loss during and after operation. Usually the patient had a multiplicity of errors compounding one another. There were nine technical errors, five of which were directly responsible for the patient's demise. There were six patients in whom there was excessive blood loss at operation and in five of these, it was considered important. Pancreatitis, false passage, leakage of the suture line, blown duodenal stump, damage to the portal vein, leakage from the ulcer bed, ligation of the middle colic artery and laceration of the liver were technical errors which played a part in the demise of these patients (table 10). Although many of them were treated by residents, these dangerous "rocks and shoals" should ever be foremost in the surgeon's mind.

Four patients died of unavoidable complications. One had a pulmonary embolism, another intraperitoneal bleeding due to what we called "oozing disease," another, the aforementioned cirrhotic with bleeding at the ulcer site, and the fourth a blood transfusion reaction. It is hard to evaluate a condition such as "oozing disease;" nevertheless, any experienced surgeon has encountered it at some time in his career. It is our opinion that this is the result of suboxygenation and inadequate transfusion in the preliminary phases of management, and once it develops, there is little that one can do to control it. Giving a pint of fresh blood[10] every fourth transfusion should help prevent this condition.

Anesthetic deaths continue to present themselves and are always catastrophic. There were five errors, noted in the charts, one considered primary, in which the anesthesia was incriminated. Amongst them were a questionable air embolism, an aspiration postoperatively, and local as a poor choice of anesthesia; this last is mentioned in that it was thought to be a factor in the rupture of the stomach in one of the cases. Good anesthesia, as well as a qualified surgeon, is certainly necessary for the care of these acutely ill patients.

Discussion of the Medical and Surgical Deaths.—There were six hopeless medical deaths and one "hopeless" surgical death which was so classified as the result of a coronary condition; this patient should not have been subjected to operation (table 11). Four of the medical patients received inadequate medical therapy and had they been adequately transfused, would no doubt have survived. This is one of the areas in which aggressive therapy is certainly of paramount importance. Three of these four patients died of inadequate transfusions; one received water instead of blood and died of hemodilution. Four other medical patients who died should have had surgical treatment. Of two with diagnostic errors, one received 17 pints of blood over a 24 hour period on the basis of a diagnosis of varices instead of ulcer. The other was a jaundiced patient,

Table 10. — Thirty-Four Peptic Ulcer Deaths Specific Surgical Errors Technical Errors

Pancreatitis
? False passage
* Proximal gastrectomy suture line leakage
* Blown stump
* Portal vein tear 18 pints (associated hepatic artery aneurysm)
Postoperative ulcer, bleeding after suturing ulcer bed
* Ligation of middle colic artery
* Laceration of liver

* Primary errors

Table 11. — Fourteen Medical Deaths Analyzed

	Six Hopeless From Outset
1. 84 years	Emphysema with auricular fibrillation
2. 72 years	Coronary. Admission hemoglobin 10.0. Received 3 pints blood
3. 37 years	Metastatic carcinoma of cervix
4. 81 years	Cancer of prostate. Nonprotein nitrogen 92
5. 23 years	Quadriplegic. Admission hemoglobin 7.0 Received 10 pints blood
6. 76 years	Congestive Heart Failure. Blood urea nitrogen 356
	Four Inadequate Medical Therapy
1. 73 years	Admission hemoglobin 5.0. Received water instead of blood
2. 65 years	Admission hemoglobin 6.0. Received only 3 pints of blood in 90 hours
3. 46 years	Hemoglobin not done. Hematemesis for 3 days. Expired 13 hours after admission Only 1 pint of blood was given 15 minutes prior to demise
4. 42 years	Admission hemoglobin 4.0. Received only 4 pints of blood in 8 days
	Four Should Have Had Surgery
	A. Error Due to Diagnosis
1. 41 years	Admission hemoglobin 8.5. 17 pints blood/24 hours. Varices vs. ulcer (autopsy-ulcer)
2. 66 years	Admission hemoglobin 14.0. 32 pints blood/78 hours. Jaundiced. Two months past coronary. Carcinoma vs. ulcer (autopsy-ulcer)
	B. Excessive Delay
1. 7 weeks	Admission hemoglobin 7.0. 5 pints blood/8 days (autopsy-ulcer)
2. 47 years	Admission hemoglobin 9.2. Hemoglobin 7.5 after receiving 5 pints of blood. Expired 13 hours after admission (autopsy-ulcer)

Table 12. — Three Excessive Medical Delays Treated Surgically

1. 28 years	Surgical intervention advised 18 hours prior to operation. Received 14 pints of blood. Expired 32 hours after admission.
2. 47 years	Admission hemoglobin 9.2. Hemoglobin 7.5 after receiving 5 pints of blood. Expired 13 hours after admission
3. 52 years	Received 9 pints of blood 110 hours prior to surgery; total 17 pints. Expired; multiple acute ulcers

who was thought to have a carcinoma of the ampulla of Vater, which, after 32 pints of blood had been administered and a 72 hour period had elapsed, proved on autopsy to be a bleeding posterior bulbar duodenal ulcer. A third patient seven weeks of age, with bleeding for a period of eight days, could possibly have been saved had there been early surgical intervention. The fourth was exsanguinated while surgical intervention was being made available.

Of the surgical cases, three would have been better handled medically. One patient was overtransfused; another had an inadequate preoperative transfusion and the condition probably would have stabilized on medical therapy; and a third died because of an error in diagnosis of coronary disease in the belief that the deteriorating condition of the patient was due to a bleeding ulcer (table 12). There were seven surgical cases in which death was directly attributed to inadequate preoperative transfusion, and in three of these there was excessive medical delay. There were five primary technical errors, a finding which points out the hazard of performing an operation of this magnitude without exercising careful judgment and skill. Making up the hard core from the surgical viewpoint are the four unavoidable complications (table 13).

From a theoretical point of view, 10 of these cases, including the medical hard core, were not salvagable, making a theoretically salvagable group of 24 patients. It might be well to conclude this point by citing the famous saying of Whittier:

> For of all sad words of tongue or pen,
> The saddest are these: "It might have been!"

Table 13. — Primary Errors in Surgical Cases Leading to Demise

Inadequate preoperative transfusions, earlier surgery (includes 3 excessive medical delays)	7
Should have had medical therapy	3
Coronary	
Overtransfused	
Inadequate transfusion, but would have stabilized on conservative management	
Anesthetic death	1
Technical errors	5
Suture line leakage	
Blown stump	
Portal vein tear	
Middle colic artery ligation	
Lacerated liver	
Unavoidable complications	4
Blood transfusion reaction	
Pulmonary embolism	
Postoperative ulcer bed bleeding in a cirrhotic	
Oozing disease	

Summary

Massive hemorrhage can be, and often is fatal when not treated.

Most massive bleeding in this series occurred from sudden erosion into a large vessel. In over half of the patients the onset occurred one day or less prior to admission.

Less than one third of the patients had a previous history of massive bleeding.

About two thirds had a documented history of ulcer.

Hematemesis occurred in all but two and melena in all.

In 77 per cent of the patients the bleeding occurred after the age of 50; fatal hemorrhage may occur at any age.

Cardiovascular disease is the most common associated disease, but the most hazardous is pulmonary emphysema.

Over half of the bleeding sites were due to posterior penetrating duodenal ulcer; less than one third were gastric.

The rate of blood loss is a most important factor; in half of this group the loss of blood was greater than 1 pint every eight hours.

The most important error in management was inadequate transfusion.

Mediosurgical rivalry has no place in management.

Earlier surgical intervention is urged in many, but not until a concerted attempt at restoring the blood volume has been made.

The patient should be seen as soon as possible by both the surgeon and the internist.

If bleeding recurs on conservative management, operation is indicated.

If a patient continues to lose more than 1 pint of blood every eight hours within the first 24 hours, that is, 1,500 cc. after the initial blood volume replacement, he should be operated on.

The optimum time for surgery is early in the second 24 hour period, and the recognition of a "point of no return" should be considered before the 48 hour period.

The keynote of management is individualization and intensive, vigorous, constant personal attention.

Large amounts of blood are well tolerated, but are not entirely without danger; a fresh pint of blood every fourth transfusion is recommended.

Large operative procedures and excessive blood loss at operation are to be discouraged; a simple operation to check the bleeding should be given careful consideration.

Technical and anesthetic errors are ever present and are to be guarded against.

Unavoidable complications and hopeless cases are encountered.

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Discussion

Dr. Lester R. Dragstedt, Gainesville: I should like to compliment Drs. Ferguson and Reinstine on this careful study and on their conclusions, which seem to me to be well justified. Cooperation between the internist and surgeon is a first essential in the wise handling of the massively bleeding ulcer patient. If a skilled endoscopist is available, he also should be called upon in an effort to make an accurate preoperative diagnosis. The roentgenologist, too, is a part of this team, and we need not fear his manipulations.

As many of you know, I have for many years advocated vagotomy and pyloroplasty or gastroenterostomy as the definitive surgical treatment of duodenal ulcer. It was, however, my usual practice to perform vagotomy and low gastric resection of the Billroth II type for actively bleeding duodenal ulcers. As the authors have pointed out, in recent years Dr. Joseph Weinberg and Dr. Jack Farris and their associates in Los Angeles have each reported relatively large series of actively bleeding duodenal ulcer patients treated by pyloroplasty, ligation of the bleeding point, and vagotomy. Each of these surgeons has reported an exceedingly low mortality, much lower in fact than anyone has secured by gastric resection. Since the actively bleeding duodenal ulcer patient is a poor surgical risk in spite of repeated blood transfusions, I now believe these patients should be treated by pyloroplasty, ligation of the ulcer with a heavy silk or linen suture, and vagotomy in preference to gastric resection.

Dr. James L. Borland, Jacksonville: Dr. Ferguson is to be commended for a substantial contribution to our knowledge in this field. It has been my personal belief that the statistical approach to this problem is of little avail and that specifically the mortality figures given from the large medical centers are entirely too high and tend to render us unnecessarily fearful when confronted with substantial gastrointestinal hemorrhage. These figures certainly do not conform to my experience in private practice, nor, as I came to review the figures in Jacksonville hospitals, do they agree with what has occurred in this locality.

The over-all mortality for bleeding peptic ulcer of all types is around 5 per cent with the greater proportion of the mortality as usual in the gastric ulcer group. Dr. Ferguson's paper would indicate that even this is needlessly high.

Dr. Ferguson's paper is the outgrowth of discussions in a joint medical-surgical clinic at the Duval Medical Center. It was soon realized that current "medical" versus "surgical" debates were senseless and largely stemmed from ignorance of what actually occurs. It is clear that in the over-all problem there are both elements, that the lines could be clearly drawn, and that if the gastroenterologist and the surgeon each attended to his own side and cleaned up his own house, he would be well occupied and have little time to scrounge around in the other fellow's domain.

There is certainly a small group of bleeding patients that are going to be lost no matter how careful the treatment. There will be a few cases in which the choice of surgical intervention is a matter of such delicate judgment that no one can expect always to be right. Patients, as Dr. Ferguson pointed out, will be lost with and without surgical treatment, and post hoc no clear error can be detected. For the majority of deaths in hemorrhage from peptic ulcer, however, the cause is neglect of certain basic rules. Generally fatalities result from failure to follow the patient closely enough, or violation of basic surgical rules, or faulty surgical technique.

The cardinal rule is that the physician must be prepared to attend his patient personally, that a continuing evaluation must be carried out, and that during the period of hemorrhage changes in the patient's condition be detected with sufficient speed to enable the physician to alter his program to meet them.

Medical management, which largely consists of sedation, atropinization and judicious neutralization, prevention of hunger and adequate blood replacement should be energetic and flexible.

In summary, our present procedure at Duval Medical Center, as well as in private practice, is that the patient is admitted to medical service where blood is replaced as rapidly as is feasible until a hemoglobin determination of 12 Gm. and a hematocrit reading of between 35 and 40 are reached. These figures were selected since, in general, anemia below this point becomes symptomatic and it is thought that it could contribute to deterioration of the patient. A word about transfusions—if the patient is in shock, of course, the blood may be pumped in, but only to combat shock. With shock overcome, and in the absence of shock, the patient is rather slowly transfused continuously with sufficient speed to overcome any loss of blood and to reach the desired blood level. This level is then maintained, and the amount of blood and the rapidity with which it need be injected are, therefore, an indication of the degree of the hemorrhage. It is frequently checked with the blood volume. Following each fourth transfusion, we also check the various bleeding tendencies and calcium and potassium. Good precautions are taken to warm the blood to prevent potassium accumulation and to supply calcium. We believe that there is no evidence that administration of blood, per se, injures the patient in any way; nor have we, in any of our patients in whom generalized oozing occurs, evidence of any measurable defect. We are unable to measure many things in the blood in Jacksonville, but those that we can measure are not affected.

Furthermore, the literature, we believe, does not substantiate the fact that anything is introduced into the

patient which is likely to cause bleeding. When oozing occurs, we believe that the patient has lost something which we have failed to replace. This factor is important because so much is said about the harmful effects of transfusion that people become afraid to submit to transfusion, and we think that intractable shock is, in most cases, a failure to replace blood volume adequately. When larger amounts of blood are administered and are administered more rapidly, the shock can be overcome. We think that the evidence is that it is not really feasible to blow out a clot by increasing the blood pressure within limits that are reasonable. This finding has been demonstrated adequately in dogs, and it has been our common experience. Increasing the blood volume above normal may result in pulmonary edema. This, however, will not occur so long as the patient is in shock. When shock has disappeared, the injection of blood may be slowed and blood volume measurements curtailed.

The decision as to whether surgical therapy should or should not be undertaken should be made by the physician who has been taking care of the case. Rightly or wrongly, he is the only one in a position to know. The technical part of what shall be done can be determined by the surgeon. There are several definite indications for operation: (1) If the hemorrhage continues unabated in a degree sufficient to require transfusions at five to six hour intervals, so that one will probably run out of blood. Having replaced the blood lost prior to admission, one may establish this rate readily. (2) If hemorrhage stops and then after an interval of medical treatment recurs in the same degree as of the original hemorrhage. Actually in St. Vincent's Hospital about 9 to 10 per cent of the patients are subjected to operation. Once the patient is transferred to surgical care, we believe that the surgeon should be bound by certain rules: (a) his sole duty is to stop the hemorrhage; (b) bleeding duodenal ulcer is not of itself an indication for gastrectomy; and (c) operation at the time of hemorrhage should be performed only when required by technical reasons to stop the hemorrhage. We believe that this surgical approach will reduce the mortality resulting from excessive operative procedures and that it will furthermore encourage the gastroenterologist to seek surgical aid earlier if he can be certain that a prolonged operation will not be involved unless necessary.

Again, I thank Dr. Ferguson for presenting his material, and it is a fine contribution.

Dr. Ferguson, closing: We would like to thank Dr. Dragstedt and Dr. Borland for their very informative discussions.

Surgical Treatment of Parkinsonism

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Parkinsonism is a progressively disabling disorder,[1] and medical treatment is as yet impotent to prevent eventual complete invalidism in many patients.

The surgical approach to the therapy of the extrapyramidal disorders has progressed significantly during the last few years, and a practical treatment of parkinsonian symptoms can now be offered.[2-5] Surgery can ameliorate rigidity and tremor, or make them disappear entirely. It must be stated, however, that not all patients with parkinsonism are candidates for surgery and that only the symptoms—rigidity and tremor—so far, can be attacked by this method.

The present series of patients has been operated on, with employment of a stereotactic device, to produce a lesion in the basal ganglia and destroy fibers that transmit the pathologic impulses responsible for rigidity and tremor. The lesion is placed on the left side to correct disability in the right-sided extremities and vice versa. Many methods have been employed to try to place a lesion accurately and consistently in a series of patients in a preselected site,[6-9] but it has been demonstrated that the simple stereotactic instrument devised by one of us (D.F.)[10] is the most satisfactory so far.

This instrument is composed of a platform, which is secured to the skull and upon which are mounted consecutively an x-ray guide and a needle holder with correction scales. The point to be approached is selected and with the x-ray guide in place, lines are drawn from which in the anterior posterior and lateral planes corrections from a zero line are determined. The correction angles are then adjusted on the needle holder and the preselected site is reached with precision.

In each of these patients it was possible to make an accurately placed lesion with a single needle placement. With the patient awake, the instantaneous relief of tremor and rigidity, which by follow-up over a two year period has so far proved permanent, was demonstrated.

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Report of Cases

Case 1.—A 47 year old, right-handed bench mechanic for Eastern Air Lines, referred by the Florida State Vocational Rehabilitation Commission, was examined on Oct. 2, 1958. He had had symptoms of parkinsonism for approximately three years. The first symptoms appeared as rigidity and tremor in the right arm and right foot in September 1955. At examination he showed marked rigidity and tremor of the right-sided extremities. He complained of pain in the neck and back and of constant headaches. He was practically unable to work.

Left chemopallidectomy was performed on October 28, with use of the Fairman stereotactic instrument. When the patient was examined on November 20, there was no tremor or rigidity on the right side. Motion was excellent. The gait was markedly improved. Pain on the right side of the back and neck and constant headaches had disappeared. "He now works, performing his duties as a bench mechanic as well as he did three years ago, before he became sick." His last examination on Oct. 20, 1959 was as previously. He works productively every day. There is no tremor or rigidity of the right-sided extremities.

Case 2.—A 43 year old, right-handed man, with a history of tremor and rigidity involving the right-sided extremities for the past four years, was examined on July 14, 1958. He was referred by the Florida State Vocational Rehabilitation Commission because he became unemployable.

The patient was admitted to Doctors' Hospital where, on September 29, with the use of Fairman stereotactic apparatus, a left chemopallidectomy was performed. On examination one and one-half years later, there was no tremor or rigidity whatsoever of the right-sided extremities. Motor power was normal, and a pre-existent tremor of the jaw and lip had completely disappeared. The patient is now working steadily and drives 20 miles to and from work daily.

Case 3.—A 50 year old, right-handed woman who had become unable to keep house for her brother, was referred by Dr. Erwin Perlstein of Louisville, Ky. Her first symptoms appeared eight years previously as pain in her right shoulder, followed by tremor of the right hand. The symptoms gradually became worse. One year before consulting us, she had been operated on in another hospital with no improvement. At examination, she presented bilateral alternating regular tremor with rigidity more marked on the right. A right-sided chemopallidectomy was performed on Oct. 3, 1958.

The patient was re-examined on March 10, 1960. She walked practically normally. She reported that she is able to do all the housework, shower in 10 minutes, pull on her girdle, drive her car, and stoop, bend, work with the vacuum cleaner and perform all the activities of a normal woman. It was remarkable how her facial expression had returned to normal. There was some rigidity in the right upper and lower extremities with a slight tremor on the right side. The left side showed no rigidity and no tremor.

Discussion

In the first two cases rigidity and tremor were treated in patients with "early" parkinsonism, in whom the extremities of only one side were involved. Their symptoms were entirely relieved.

In the third case the bilateral manifestations of "more advanced" parkinsonism were present. In such patients it is possible to relieve or completely abolish the motor abnormalities of one side, at least, and thus enable a patient to manage better his daily activity, work and social affairs. It is most important to understand that relief of symptoms in the extremities of even one side in these patients is a guarantee against the inevitable complete invalidism that befalls many patients with this "disease."

Certain contraindications to surgical therapy such as more generalized cerebral organic deterioration, psychoses and severe hypertension, may preclude the benefits of chemopallidectomy.[11]

A series of 29 patients was operated upon by us to relieve abnormal involuntary movements and/or rigidity. Of these patients 21 were parkinsonian and eight were "cerebral palsied." Of the 21 with parkinsonism 20 were relieved partially or completely of their symptoms. There were no operative deaths in this series, and hemiplegia did not occur.

It is believed that these results are due to the careful selection of patients, a fundamental understanding of the pathogenesis of the parkinsonian complex, and the use of the Fairman stereotactic device which permits the precise placement of a lesion in a preselected site.

Summary

The application of a new instrument in a series of patients with parkinsonism is presented.

Three cases are reported, representing "early" and "more advanced" types of this disorder.

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Use of Antiabortion Components in Routine Antepartum Dietary Supplement

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Since the majority of abortions in an obstetrical practice occur in that large group of patients where no trouble is expected rather than in the small group of habitual aborters who usually receive most of the attention, we realized that unless antiabortion measures were used on all patients, there could be no general lowering of our abortion rate. We adopted the procedure of adding to the routine antepartum supplement antiabortion components to see what effect they would have on our incidence of abortions. This paper is devoted to our activities with little discussion of the various theories or other studies on abortion. Our opinions are supported by data collected under controlled conditions on patients in groups that are sufficiently large to be of statistical value.

Our control group comprises those patients who were seen from the time this practice was first established by one of us in 1952 until July 1956. In their management they received the same basic dietary supplement as those who received the antiabortion supplement. By using our own control group we have definite figures for comparison rather than relying on a nebulous national average. Also, the incidence of abortions in our hospital (excluding our patients) from July 1, 1956 to March 1, 1959 was 12.8 per cent.

In this study we departed from the usual procedure in that, in addition to all patients who were pregnant on their first visit, we also included those who were actively aborting and those who had freshly aborted. This group gave a fairly good picture of the total incidence of abortions occurring in our practice, but a percentage higher than if we had used only those patients who were pregnant at the time of their first visit.

During the period when the special components were added to the diet, in addition to those patients who were pregnant we likewise included those who were actively aborting and those who had freshly aborted to our percentage of abortions. This period extended from July 1, 1956 to March 1, 1959. During this time a total of 2,025 patients was seen. Those patients who were actively aborting and those who had already aborted did not receive antiabortion therapy for obvious reasons. There were also a few patients that aborted who failed to get the special medication for one reason or another. These were included here. All others including those who were bleeding moderately on their first visit and the habitual aborters were put on the same general management, except the dose was doubled during the first four months for those who were bleeding or had bad obstetrical histories. Five habitual aborters continued to abort on the special dietary supplement, but they were lumped together with the others without any special classification.

By including all patients under one blanket type of management we were able to get a fair idea as to the effect of the special dietary supplement on the abortion rate in our practice. This approach gave us almost 50 per cent reduction in abortions and would have been better had we not included those in our percentage whose pregnancies were beyond retrieve when first seen.

The antiabortion components were put in a capsule separate from the routine antepartum capsule for the first years; thereafter, they were included in an antepartum capsule which has the trade name Hi-Vi Caps. The recommended dose of both the capsule that contained only the antiabortion components and the antepartum capsule in which they were later incorporated was two capsules daily for most patients. If the patient was bleeding or had previous abortions, a dose of four capsules a day was recommended for the first four months and two thereafter.

One of the antiabortion components is a dose of 200 mg. of ascorbic acid in each capsule. The importance of ascorbic acid has been well established for both the growth and maintenance of new tissues. The other component is a dose of 60

mg. of hesperidin - methylene - carboxy - chalcone, which is a comparatively new water-soluble derivative of hesperidin. Its biological action is exhibited as a stimulant to the growth processes, and it is used in other fields of medicine to stimulate healing in such entities as ulcerative lesions. It is also used in hemorrhagic conditions due to vascular fragility.

By using a large dose of ascorbic acid we do not find it necessary to rely on dietary sources to get a uniform daily intake. We are of the opinion that the dose of ascorbic acid recommended by the Council on Foods and Nutrition is not adequate for some patients and believe that our results justify this opinion as the control group of patients received ascorbic acid within the dose range recommended.

We encountered seven abortions that exhibited molar changes in varying degrees and one choriocarcinoma. Three of the patients with hydatid moles received the antepartum capsules. We believe our unusually high incidence of moles is a chance phenomenon.

Analysis of Data

(1) (Based on 897 patients) (Control Group)	14.6 per cent of the total number of patients who were seen during the control period aborted.
(2) (Based on 2,025 patients, which is the total number seen during the period of special therapy)	4.64 per cent (94 patients) of the total number of patients seen during the period of special therapy aborted without receiving treatment. Some of them were actively aborting when first seen; some had already aborted, while others missed getting the special medication for one reason or another.
(3) (Based on 2,025 patients)	2.96 per cent (60 patients) is that part of the total number of patients seen during the period of special therapy who aborted subsequent to their first visit. They received the special dietary supplement.
(4) (Based on 1,931 patients)	3.05 per cent (60 patients) of the patients who were pregnant at the time of their first visit received the special medication but aborted. This is the same group of aborters as in (3), but the per cent is calculated on the number who were pregnant at the time of their first visit and received antiabortion therapy.
(5) (Based on approximately 1,800 patients. Among these were a goodly number of patients with bad obstetrical histories)	1.8 per cent of that part of the patients who were having no trouble at the time of their first visit aborted. This is the per cent that might be approached if all patients are given adequate antiabortion therapy soon after they miss the first menses. The degenerative changes that precede abortion in most cases usually begin well in advance of the actual onset of the abortion. We are of the opinion that early antiabortion therapy may prevent a large part of such changes.

Summary and Conclusions

That part of the total number of patients seen during the period of special therapy who aborted and received no antiabortion therapy 4.64%

That part of the total number of patients seen who aborted after receiving medication 2.96%

Total per cent of abortions encountered during the period of special therapy 7.60%

Abortions during control period 14.60%

Abortions during period antiabortion therapy was used 7.60%

Salvage 7.00%

This was a controlled study on groups of patients sufficiently large to be statistically reliable.

Had we counted only patients who were pregnant and received special medication on their first visit, including the moderate bleeders and those with bad obstetrical histories, the per cent of abortions would have been 3.05 per cent during the period of special dietary therapy.

The abortion rate among patients who registered and were put on antiabortion therapy before they had bleeding was only 1.8 per cent.

This study was made to determine the effects of a dietary supplement containing antiabortion components on the over-all abortion percentage. The only departure from uniform management was that the patients who were bleeding and those with bad obstetrical histories were put on four capsules a day for the first four months instead of the usual two.

The use of special antiabortion components in the dietary supplement is obstetrically sound and economically feasible.

The material used in this study was supplied by Tropic Drug Company, Fort Lauderdale.

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The Use of Newer Psychiatric Drugs in Medical Practice

Their Specificity of Action in Relation to Target Symptoms and Dynamic Situation

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Recently many new drugs have come into use for the treatment of emotional disturbances. Although the use of the drugs themselves plays only one part in the over-all treatment of emotional disorders, their very availability has made a great impact on treatment, and they have provided inestimable benefit to patients. Their mushrooming growth, however, has been associated with some disadvantages. With such a vast array of psychopharmacologic drugs available, it has often been a matter of chance as to which drug has been chosen for a given patient; as a result, patients and physicians have been unnecessarily disappointed on many occasions. It is the purpose of this paper to illustrate that each drug has a definite specificity for particular clinical conditions so that a more satisfactory choice is usually possible.

Table 1 lists some of the drugs currently available, with the usual dosages and commoner side effects. These include (1) phenothiazines, (2) rauwolfias, (3) minor tranquilizers, and (4) antidepressants. Typical examples of each group, given in the same order, are: (1) chlorpromazine (Thorazine), (2) reserpine (Serpasil), (3) meprobamate (Equanil and Miltown), and (4) nialamide (Niamid) and imipramine (Tofránil). From the table it can be seen that, in general, the more effective the drug the more severe are the side effects, and that all of these drugs have significant dangers. For example, chlorpromazine (Thorazine), perhaps the most effective drug for hyperactivity, produces a great number of cardiovascular and central nervous system side effects, and the danger of hepatitis and agranulocytosis.

The initial aim of use of these drugs is the relief from intense disruptive emotions, so that the patient might more fully utilize resources within himself and his environment to achieve a more effectual way of living. On a longer term basis, use of drugs might serve to decrease basic difficulties such as thinking disturbances, or more likely to minimize the intensity of discomfort due to the chronic presence of anxiety-provoking situations which cannot be modified. Thus, drugs can help in the effort toward fuller use of available resources which are interfered with by the emotional illness. For example, the presence of depression, fatigue and hopelessness may prevent the expenditure of effort towards health; and the presence of bizarre delusional thinking may prevent adequate perception of, and relationship to, the real world.

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DRUGS			SIDE EFFECTS			
GENERIC NAME	TRADE NAME AND COMPANY	DOSAGE IN MILLIGRAMS	GASTRO-INTESTINAL	CARDIO-VASCULAR	EXTRA-PYRAMIDAL	IDIOSYNCRATIC AND OTHER
I. MAJOR TRANQUILIZERS						
PHENOTHIAZINES						
Chlorpromazine	(Thorazine—SKF)	25-100 qid	X	X	X	Hepatitis, agranulocytosis
Promazine	(Sparine—Wyeth)	50-200 qid	X	X	X	Hepatitis, agranulocytosis
Mepazine	(Pacatal—Warner-Chilcott)	25-50 tid	X	X	X	Atropine-like
Prochlorperazine	(Compazine—SKF)	5-30 tid		X	X	More extrapyramidal
Perphenazine	(Trilafon—Schering)	2-6 tid		X	X	More extrapyramidal, restlessness
Promethazine	(Phenergan—Wyeth)	100-150 qd				(little effectiveness)
Trifluprazine	(Vesprin—Squibb)	100-150 qd			X	More extrapyramidal
Trifluoperazine	(Stelazine—SKF)	1-8 tid			X	More extrapyramidal
Thiopropazate	(Dartal—Searle)	2-10 tid			X	More extrapyramidal
Thioridazine	(Mellaril—Sandoz)	25-200 tid				(Data suggest fewest side effects)
RAUWOLFIAS						
Reserpine	(Serpasil—Ciba)	½-1 bid	X	X	X	Skin rash; peptic ulcer ruptures; depressions
Deserpidine	(Harmonyl—Abbott)	¼-2 tid	X	X	X	Data incomplete
Rescinnamine	(Moderil—Pfizer)	¼-½ bid	X	X	X	Data incomplete
II. MINOR TRANQUILIZERS						
PROPANEDIOLS						
Meprobamate	(Miltown—Wallace; Equanil—Wyeth)	200-400 tid	X	X		Skin rash, edema, habituation
	(Ultran—Lilly)	300 tid				Data incomplete
III. ANTIDEPRESSANTS						
HYDRAZINES						
Ipronazid	(Marsilid-Hoffmann-La Roche)	10-25 tid		X		Hepatitis, atropine-like, confusion
Phenelzine	(Nardil—Warner-Chilcott)	15 tid decreasing to daily	X	X		Data incomplete
Phenaglycodol hydrazine	(Catron—Lakeside)	3 qd		X		Hepatitis, visual color disturbance
Nialamide	(Niamid—Pfizer)	25-50 qid		X		Restlessness (data incomplete)
AMPHETAMINES						
Dextroamphetamine	(Dexedrine—SKF)	2½-10 tid	X	X		Anxiety, restlessness
Dextroamphetamine	(Dexamyl—SKF)	5 tid	X	X		Anxiety, restlessness
with amobarbital		30 tid	X	X		Anxiety, restlessness
Methamphetamine	(Desoxyn—Abbott)	2½-5 tid	X	X		Anxiety, restlessness
OTHERS						
Methylphenidate	(Ritalin—Ciba)	5-10 tid	X	X		Anxiety, restlessness
Pipradrol	(Meratran—Merrell)	1-2½ tid	X	X		Acute anxiety, restlessness, skin rash
Deanol	(Deaner—Riker)	25 tid	X	X		Data incomplete
Imipramine	(Tofrānil—Geigy)	25-75 tid		X		On high dosage, diplopia, tremor, seizures

IV. NONBARBITURATE SEDATIVES AND HYPNOTICS				
Methylparafynol	(Dormison—Schering)	250-500 bid	X	Mood lability, distorted time sense, depression, drowiness
Glutethimide	(Doriden—Ciba)	250 tid	X	Skin rash, addiction, fatigue, drowsiness
Ethchlorvynol	(Placidyl—Abbott)	250-500 bid		Drowsiness, fatigue, data incomplete
Methyprylon	(Noludar—Hoffmann-La Roche)	50-200 bid		Drowsiness, fatigue, data incomplete
Oxanamide	(Quiactin—Merrell)	800-1000 qd		Drowsiness, fatigue, data incomplete
Ethinamate	(Valmid—Lilly)	500 tid		Drowsiness, fatigue, data incomplete

Target Symptoms

These drugs have specificity in terms of readily observable target symptoms. For instance, chlorpromazine (Thorazine) is specifically indicated for hyperactivity, hostile aggressiveness, sexual unrest, and severe anxiety, but contraindicated in mild anxiety and depression. Meprobamate (Equanil and Miltown) is indicated for mild anxiety and muscle tension; barbiturates for mild anxiety and insomnia. Thus each group of drugs has specificity in relation to target symptoms. Variations within each group of drugs make finer choices possible, as for example, chlorpromazine (Thorazine) for severely disturbed patients with physical hyperactivity, but trifluoperazine (Stelazine) for similarly disturbed patients with lethargy.

Specifically, the choice of drugs can first be considered from the standpoint of the primary target symptoms against which they are to be directed. Table 2 lists some of the commoner target symptoms in the left-hand column, and to the right lists clinical estimates of relative effectiveness of various types of drugs. In some instances, a drug may have a positive benefit (shown by +1 to a maximum of +3) or a negative disadvantage (−1 to −3). In addition, a drug's initial effectiveness may rapidly decrease, as with barbiturates, where initial high effectiveness for insomnia rapidly diminishes as tolerance to the drug develops. This fall-off is indicated by the symbol following the effectiveness number; with reference to barbiturates, for example, +3− indicates high initial effectiveness, but decreasing effectiveness with continued administration.

It should be emphasized that target symptoms, as used herein, are clinical symptoms clearly recognizable by every physician, and are not limited to detection by a specialist in psychiatry. Hence, the practitioner can rely on his usual clinical techniques and observe the presence, in speech or action, of such symptoms as anger, hyperactivity, irritability, sadness, slowness, elation, resentment, and suspicion. The physician can always make note of the target symptoms displayed by the patient, whether in the office, home, or hospital, and of the characteristic ways in which the patient handles routine responsibilities and stresses, as well as his relationships to the physicians, staff, and other persons.

Dynamic Situation

In addition to the readily observable target symptoms, many physicians know a patient in

Table 2. — Target Symptoms and Estimated Clinical Effectiveness of Psychopharmacologic Drugs

Target Symptoms	Major Tranquilizers		Minor Tranquilizers	Antidepressants			Sedative-Hypnotics
	Phenothiazines (Chlorpromazine)	Rauwolfias (Reserpine)	Propanediol (Meprobamate)	Hydrazines (Nialamide) (Phenelzine)	Amphetamines (Dextro-Meth-Amphetamines)	Imipramine	Barbiturates and Nonbarbiturates
Anxiety	1+	1+	+3-	0	-3	0	+2-
Overactivity Restlessness Tension	+3	+2	+2-	-1	-3	-1	+2-
Aggression Hostility Destructiveness Impulsivity	+3	+2	+1-	-1	-2	-1	+1-
Panic Fear	+3	+3	+3-	0	-1	0	+2-
Sexual unrest	+3	+2	+1	0	-1	0	+1-
Depression Withdrawal	-1	-3	-2	+3	+2-	+3	-3
Insomnia	+2	+2	+2-	-1	-3	-1	+3-
Hallucinations Delusions	+2	+1	0	0	0	0	0

great detail, and thus can use knowledge of the underlying personality and illness in effecting a more precise selection of treatment. The dynamic situation—the balance of forces at play which result in the target symptoms—can then be used to provide an even finer discrimination in the selection of the drug. The major symptoms alone may suggest one of several drugs, or a combination, but the dynamic situation determines the most appropriate selection. Thus, a clinical impression of the personality dynamics and variety of symptoms present can be made, and used for a more judicious choice of drugs, if a drug is necessary at all.

Case Material

The following examples illustrate how the target symptoms indicate the general kind of drug to be used, and how a knowledge of the dynamic situation further narrows the field.

1. Underlying emotional problems determine the choice of drugs: For example, in depression:

A. A male patient is depressed, tense, and slow, but by his every glance and reference also demonstrates veiled anger at, and resentment of, his wife. To give him an antidepressant such as imipramine (Tofrānil) alone will often simply release energy which might cause the eruption of violence directed outwardly towards his wife or inwardly towards himself. In this case, the simultaneous use of a phenothiazine with minimal sedative properties, such as trifluoperazine (Stelazine), could serve to decrease the intensity of the hostile feelings so that they would not be overwhelming and could be dealt with through environmental or individual means while the depression was being relieved by the imipramine.

B. In contrast, if a similarly depressed patient is seen, but with little or no evidence of underlying hostility and the depression seems to be due to a deep loss, then a phenothiazine would be contraindicated as it would be likely to worsen the depression. An antidepressant of the monoamine oxidase inhibitor type, such as nialamide (Niamid) or phenelzine (Nardil), or of another type such as imipramine (Tofrānil), would be indicated in addition to a supportive relationship by the physician. The combination would aim to increase the patient's sense of worth through the physician's demonstrated interest and effort.

C. A third example is the depression which seems to be due almost entirely to angry resentment, handled by being held in. Here the use of phenothiazines alone, plus adequate measures to deal with both the sources of the anger and the means for its appropriate expression, would be indicated.

2. Side effects of drugs are important in certain situations: For example, acute anxiety: Another example of the importance of dynamics on the choice of drug occurs when the target symptoms are those associated with a panic reaction—intense anxiety, hyperactivity, insomnia, restlessness, fear, disruptive thoughts. Here, it is essential to alleviate these intense feelings because they cannot be tolerated for long without serious results. At the earliest stages, sedation alone, such as with meprobamate (Equanil or Miltown) or barbiturates, is generally very helpful to permit therapeutic intervention. If the environmental stress, or inner disruptions, cannot be handled simply, then use of a phenothiazine such as chlorpromazine (Thorazine) would be indicated to allay motor hyperactivity, permit sleep, and facilitate communication. Even here, however, the personality of the patient would be very important, since the meaning of the side effects of such medication often is an added threat.

Thus, in a patient who has autistic or peculiarly individual ways of perceiving himself and the world around him with daydreaming, isolation, and bodily overconcern, the frequently observed side effects of phenothiazines such as orthostatic hypotension and a sense of muscular and bodily restlessness, may have frighteningly new meanings to him. Recently, for example, a boy of 16 was given a phenothiazine drug—prochlorperazine (Compazine)—to help contain outbursts of angry destructiveness while attempts to help him receive psychotherapy were under way. Within a few days there developed minor sensations of spasm of the neck and throat muscles (dyskinesia), related to extrapyramidal side effects of the drug. He reacted to these as if his body were disintegrating or being attacked in a throttling retaliation for hostile and erotic thoughts, and became panicky; he suffered brief spells of throat spasm with cyanosis relieved transiently by sedation and finally only by a very intensive supportive psychotherapeutic session. The phenothiazine was then discontinued, and subsequently only simple sedatives were used infrequently to decrease the intensity of agitated periods. It can be seen, therefore, that the simple medication worked; the more powerful medication produced danger because of its very power and far-reaching effects.

3. DIRECT EFFECTS OF DRUGS NEED TO BE EVALUATED FROM THE STANDPOINT OF THE PERSONALITY AND EMOTIONAL CHARACTERISTICS OF THE PATIENT.

A. The recognition of a meticulous, detailed, compulsive personality in a patient suggests that he depends on rigid control for a sense of safety, and would warn the physician that a drug should be chosen which would be the least disruptive of the patient's conscious control of himself and his environment. Here, the use of sedatives at time of sleep would be indicated if insomnia were severe, but only a minimal use of drugs such as phenothiazines or rauwolfias with their disturbing side effects interpretable as loss of self control (for example, hypotension with dizziness and weakness, extrapyramidal symptoms, blurring of vision).

B. An impulsive patient with little ability to plan far ahead would be given a small amount of longer-acting drug since he would be unlikely to take doses at regular and frequent intervals, and might then miss the desired beneficial effects at a moment of stress and impulsivity when he would also be prone to take an overdose.

C. If a person dependent on continued motor activity for a sense of adequacy and well-being appears to need a phenothiazine drug, he will usually do best with a less sedative preparation such as trifluoperazine (Stelazine), especially during the waking hours; reserved for sleeping hours would be a more sedative one, such as chlorpromazine (Thorazine) or a simple sedative.

Summary

Drugs have assumed a major role in the medical management of emotionally disturbed patients. The present paper includes illustrative case material, and tables on target symptoms and the side effects of psychopharmacologic agents, to point out the specificity of action which these drugs demonstrate. Their maximum efficiency can be achieved with the use of two criteria. The first criterion is the nature of the patient's target symptoms, which can be readily observed in everyday practice. The second criterion is the nature of the dynamic situation, usually well known to the family physician.

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When Will the American Surgeon Come of Age?

Amos R. Koontz, M.D.
BALTIMORE

It is common knowledge that American surgery now leads the world. Surgeons know that this was not always so, but is indeed a recent development. My thesis is not to discuss American surgery, but the American surgeon, both with regard to his privileges and his obligations.

Even in the early days of American surgery when we were groping along trying to find ourselves, we find many things to be proud of, a recital of which makes the pulse beat faster and makes us hope that the heritage of our ancestors will never be lost.

Early Achievements

Some of the most notable early achievements in American surgery were made in the South, and now that our friends in the North are forcing us to fight the Civil War again, and are doing their best to impose another Reconstruction Period on us, I think we are justified in taking a little chauvinistic pride in our native land. The first successful abdominal operation performed in the Americas was performed in my native state of Virginia by Dr. Jesse Bennett in January 1794. This was a Caesarian section performed on his own wife, who had an obstructed labor. Dr. Bennett called in two physicians, who attempted forceps deliveries unsuccessfully, and then left him alone with his wife. With the aid of two Negro servant women he performed a Caesarian section and removed both ovaries before closing the abdomen. Both his wife and the baby daughter lived and survived until old age.

Dr. Ephraim McDowell, a Virginian who had moved to Kentucky, performed his first ovariotomy in 1809 and subsequently performed the operation 12 times. John King, of South Carolina, in 1816 operated on a woman with extrauterine pregnancy by incising the vaginal wall and applying pressure on the abdomen above and forceps to the fetus from below. Both mother and child survived. Joseph Glover, of South Carolina, in 1813 did a successful hysterectomy. Prior to that, in 1801, he had performed the first splenectomy, with recovery of the patient. Marion Sims, of South Carolina, with his paper published in 1852, put the operation for vesicovaginal fistula on the map, although six successful operations for the condition had been reported before that, the first by Joseph Peter Mettauer, of Virginia, in 1840. Nor must we forget Crawford Long, of Georgia, who introduced anesthesia. The list could be greatly extended.

After the advent of antiseptic surgery, two of the leaders were Matas of New Orleans and Halsted of Baltimore. Alton Ochsner[1] stated that Halsted probably exerted a greater influence on surgical training than anyone else in the world. He introduced the experimental method of teaching in surgery, and was the first to use the residency system of training in surgery. A leading European surgeon, Prof. Lambert Rogers of Cardiff, remarked, when I visited his clinic a couple of years ago, that he considered Halsted the first modern surgeon. (Thank God he didn't say modern Republican!) He went on to explain that what he meant by that was that Halsted first enunciated all the fundamental principles of surgery, which every well trained surgeon anywhere in the world uses every time he operates today.

Low Standards

In spite of these remarkable, not to say amazing achievements, the average of American surgery and of medicine in general was not good. That is to put it mildly. A great many of our medical schools were of the proprietary type, run more for personal gain than to further medical education. English journals towards the end of the nineteenth century referred repeatedly to the low quality of the American medical degree. And justly so! When the distinguished British surgeon, Sir William Macewen, of Glasgow, was offered an appointment by the Johns Hopkins University, he had so little faith in American medicine that he stipulated that he be allowed to bring his whole staff of nurses along. Johns Hopkins withdrew the offer.

Read before the Florida Association of General Surgeons, Jacksonville, April 10, 1960.

Even after the founding of the Johns Hopkins Medical School in 1893 established a high standard of medical education in America, there were many medical schools which consisted only of courses of lectures during four or five of the winter months, the same lectures being repeated the next year, and almost automatically resulting in the conferring of the M.D. degree.

Henry Pritchett, President of the Carnegie Foundation for the Advancement of Teaching, became interested and secured the services of Abraham Flexner to make a survey of American medical schools. Flexner[2] did a monumental piece of work and his findings were a shameful disgrace to American medicine. There were at that time over 150 medical schools throughout the United States and Canada. He found that the entrance requirements were enforced in only 10 of the medical schools in this country. He found that 140 of the schools had libraries that were inadequate or had none at all. In 139 of the schools the laboratories were deplorably equipped and poorly conducted. In one medical school Flexner asked the Dean if the school had a laboratory. "Surely," the Dean replied, "I have it upstairs; I will bring it down to you." Then the Dean went upstairs and brought down a small sphygmograph.

With such a number of poor medical schools, it meant that there was an overproduction of very poor doctors in this country. Many of the medical schools had no hospital facilities whatsoever and their graduates were turned loose on the unsuspecting public totally unprepared.

Flexner's report was published in 1910. Its revelations shocked the American Medical Association into action. That organization then classified all the medical schools in the country as A, B, or C schools. To be an A school, the school must require two years of college for entrance and must have a minimum of laboratory and hospital facilities. The B and C schools could not stand the down grading publicity and gradually went out of existence, so that now we have only Class A schools in the country. This change has taken a long time, but it has resulted in a high quality of American doctors and the process is a continuing one.

In spite of the general improvement in American education, there remained grave defects in the practice of medicine. Many hospitals were poorly equipped. Their laboratories were almost nonexistent. Pathology was poor. Records, if any, were poorly kept. This condition was especially true of hospitals not connected with medical schools.

There also still remained many evidences of selfishness among many members of our profession. Many doctors, by withholding hospital privileges, made it difficult for young doctors to settle in their towns. Fee splitting was a widespread evil, especially in the Middle West. Twenty five years ago, in talking with one midwestern general practitioner, who was a friend of mine, he would not believe me when I told him that I had never split fees. It was such a routine matter in his community that he believed it to be everywhere else.

American College of Surgeons Seeks Improvements

The American College of Surgeons has valiantly tried to remedy some of these ills. It has consistently stood against fee splitting, and there is reason to believe that this practice is much less general, in those parts of the country where it was prevalent, than was formerly the case. The College also in 1920 started a system of accreditation of hospitals "to create in the hospital an environment which will assure the best possible care of the patient."[3] Whether a hospital was accredited or not was based on periodic inspections of that hospital by personnel assigned by the College. Unquestionably, many of our hospitals needed policing. The American College of Surgeons did a fine job, especially with regard to getting the hospitals to improve their laboratory and library facilities and their record keeping. The residency training programs were also improved and hospitals which were not accredited had difficulty in getting house officers.

Role of Joint Commission on Accreditation of Hospitals

In 1951 the American College of Surgeons turned its work of accreditation over to the Joint Commission on Accreditation of Hospitals, which consisted of members from the American College of Surgeons, the American College of Physicians, the American Medical Association, the American Hospital Association, and one member from the Canadian Medical Association (since discontinued). This Commission, instead of consolidating the gains made by the American College of Surgeons, started emphasizing all sorts of picayunish details which are useless and time-consuming and very annoying to busy and able doctors who are doing their best to care properly for their

patients. Busy doctors are required to attend many useless staff meetings and committee meetings, which are held simply to meet the requirements of the Accreditation Commission. With their time so taken up, many of them no longer attend city and state medical meetings, which they formerly never missed. The Commission also requires elaborate minutes to be kept of every staff or committee meeting. Besides, charts must be signed in half a dozen places, much to the annoyance of the staff. These requirements are not only annoying but expensive, as they require the employment by the hospital of additional personnel. It must be remembered that the patient ultimately pays for this. He pays for needless minutiae, of which he is totally unaware and for which the Joint Commission is responsible.

Last year, after being out of the country for two months, on arriving back in Baltimore, I found a notice from one of the hospitals of which I am a staff member stating that my privileges had been suspended until I signed one puny little history. I know that this notice was not sent out with the moral or mental sanction of the staff of the hospital, but only under the pressure of the Joint Commission. Simon Legree cracks the whip and we, the slaves, dance to the music.

What doctor with a normal pair of adrenal glands can (against his will) sign a chart in half a dozen places without having his blood pressure go through the roof? Of course, the object in having him sign is that he certifies that the history, physical examination, discharge note, et cetera, are correct. It is impossible for him to know that they are. He cannot possibly remember the details of each case sufficiently to know whether the statements made are absolutely correct or not. Even if he did remember, he would not have time to go over every sentence and make sure that no mistake was made in an entry by an intern or resident.

Another bone of contention is the type of "surveyors" sent around to inspect the hospitals for accreditation. These are often retired Army or Navy officers, who have never been in private practice in their lives, and who had never had any contacts with civilian hospitals until they accepted a job with the Joint Commission, at a few thousand dollars a year to supplement their retired pay, and then became inspectors of hospitals entirely strange to them. These men are often far inferior in professional caliber to the average of the staff of the hospital which they are inspecting. Is it any wonder, then, that there is trouble? In a recent case in one of our best Baltimore hospitals, one of these inspectors spent a whole day (mind you, a whole day!) in going over the hospital. He was too busy looking over the records and physical equipment to talk to the administrative or professional personnel. His "Recommendations and Comments" were 24 in number. Only two of them dealt even remotely with patient care. The others dealt with fire doors, stair wells, the rewriting and revising of the bylaws, and the signing of certificates and documents. It was also recommended that full minutes be kept of all the discussions at medical staff and departmental meetings and that they "be concisely recorded and reveal a thorough review and analysis of the clinical work done in the hospital." It apparently made no difference as to what type of clinical work was done, just as long as voluminous records of all meetings were kept.

Internships were formerly in great demand in this hospital and there was a plethora of applications. Largely due to the silly adverse comments of the inspector and the accrediting of the hospital for one year, instead of the usual three, interns are now hard to get. Yet the same high quality of patient care (by the same high quality staff) that has been given for years is still going on. This in spite of the Joint Commission. It is readily granted that no hospital is perfect. Every individual, every organization, and every hospital is apt occasionally to get lax in some particulars. The Joint Commission should be a help and not a hindrance in improving the status of our hospitals.

How can we remedy the present system of inspection? My suggestion is that we dispense with paid inspectors and have highly qualified physicians from other cities come and make the inspections without pay. There are many physicians who would be willing to render this service as a civic and professional duty. If such physicians were selected, they would, of course, have sense enough to discuss any defect they found with the staff, instead of sending it an edict on a completely impersonal basis months later. If the inspector found the staff unreasonable about obviously reasonable things, then higher authority should apply the pressure.

Residency Review Committee

The American Medical Association Residency Review Committee is also taking a crack at us.

Four Baltimore hospitals recently received letters dictating in detail how the residency training program should be conducted. Pressure was put on them to secure the full time services of a well qualified Director of Medical Education for internal medicine alone. If the residency training program is good, is it any business of the Committee as to just how it is conducted, whether by full time people or part time people? Besides, where is the money coming from to pay a full time Director of Education—out of the pocket of the patient again. And when will full time directors in other departments be added? Does hospital care not cost enough already?

The Committee also suggested that house staff service might be limited to private patients of physicians who contribute to the educational program. How dictatorial can the Chicago hierarchy get? Such a suggestion smacks of Russia, and not of a free country such as the United States used to be. Many men on every hospital staff teach the house men in the operating room and on ward rounds, even if they do not engage in formal teaching. Many have formerly engaged in formal teaching of both the house staff and nurses, but no longer do so for one reason or another. Are such men, after many years of fine service, to be deprived of the services of the house staff in the care of their private patients?

It should be remembered, too, that good teaching is accomplished in many ways. There is no central committee that can tell any particular hospital how to conduct its teaching. An inspiring leader in surgery is always teaching. The house staff learns something from him from the time he enters the door of the hospital until he leaves. He is full of the lore of his specialty and literally exudes it. Those who assist him in his operations and go with him on ward rounds, on either public or private patients, always learn something. These ward rounds need not be formal ward rounds either. On the job training in the taking care of patients with such men is far more valuable than formal lectures.

Who is Chicago anyway to tell Baltimore what to do? An effective residency training program was carried out in Baltimore long before the Committee was formed, yet one would think from reading its instructions that it had discovered the residency training program. It speaks glibly of "continued emphasis on graduated responsibility for residents on an increased volume and variety of clinical material, increasing the autopsy rate, training and experience on ambulant patients, and prompt completion of essential entries on medical records." All this has long been a routine matter with us. The Committee should be reminded that the residency training program was started in Baltimore by Halsted in surgery and Osler in medicine.

The letter to the Baltimore hospitals made the veiled threat that unless its suggestions were carried out by 1961, the Committee would withdraw its approval of their residency training program.

Our centralized bodies in Chicago are forcing our hospital staffs to do things (in order to get interns) which are repugnant to them and which interfere with the main function of the hospital, which is the care of the PATIENT. The central bodies should realize that the patient is the only consideration. While the object of hospital accreditation was originally to improve the care of the patient, the minutiae required by the accrediting boards now militate against his best care. It should be remembered that hospitals, doctors, nurses, technicians, laboratory workers, aides, orderlies, maids, and all the other hired help are accessories after the fact. The patient is the central figure and when a central body has imposed laborious and time-consuming conditions which interfere with the care of the patient, it is doing both the patient and the doctor a great disservice.

How did this anomalous system come about? Some of the people on the councils and committees are among the outstanding doctors in the country. Some of them, however, are hospital administrators who have never been in private practice. Others are secretaries of the councils or committees, who have never been in private practice, and who really run the show. Each time I have written articles[4-6] exposing this situation, I have received dozens of letters from all over the country approving my stand—all except one, and that was from the Chairman of the Joint Commission. One of my correspondents spoke of "our fathers who art in Chicago."

Constructive Action Urged

What, then, is the answer? The answer is that it is time for us to stand up and be counted and become masters of our own fate. If you in Florida are not satisfied with the rulings of the central bodies, I hope that your state society will take action against them, just as we have in Maryland. If all the state societies do so and cooperate in proper constructive protests, we can win

our point. One state alone can do little, although we did in Maryland succeed in getting the Joint Commission to reduce the required attendance at staff meetings from 75 per cent to 50 per cent. This is a great saving of time when one is on the staff of several hospitals.

In Maryland we started several years ago to secure a congressional hearing on the abuses in veterans' medical care. Our House of Delegates went on record as favoring it. We wrote letters to all the other state societies and all that we heard from joined us in requesting the House of Delegates of the American Medical Association to ask for a congressional hearing. We finally got that through that House of Delegates at the meeting in Dallas last December. Results can also be effected with regard to the arbitrary rulings of the central bodies if we take the same concerted action.

Challenge of the Changing Times

It is true that the deterioration of our times militates against us. This deterioration started a little more than 25 years ago. It has been due to a political philosophy which has become more and more socialistic, and more and more un-American, by centralizing our government in Washington instead of leaving it to the local communities. Remember that local self government is the foundation stone of democracy. When the federal government instituted the dole, I knew that we had taken a fatal and irretrievable step. In my native county in Virginia, we had a poor farm, to which all went who could not take care of themselves. If they were able to work on the farm, they did so. If not, they were taken care of anyway and were given free medical care. It was, however, considered a disgrace to have to receive this county help. To go to the "poor house" was unthinkable for anyone with a modicum of self respect. There were never very many there.

Soon after the federal dole was put into effect in 1933, I had a patient who was a county judge from Kentucky. He told me that before the dole went into effect there were 25 or 30 people in his county who needed help and the county was helping them, but now that the dole was in effect there were 5,000 people on relief and nobody could get any of them off. That situation has continued. We have been living in an era of "handouts" and "giveaways." Thrift and incentive have been supplanted by the doctrine of "let Uncle Sugar do it for you." This doctrine of irresponsibility has changed the very character of our people. We are lost unless we can stop it. Our country did not become great by people loafing, but by people burning the midnight oil and working hours "above and beyond the call of duty," not simply for personal gain, but from the pride of accomplishment. Those of us who can remember back to the pre-1933 days remember that we were always taught to think of our obligation to our country. Since 1933 the thought has been, not that you owe your country anything, but that your country owes you something. Just hold out your hand and let Uncle Sugar drop something into it. Do as little as you can "get by with." A whole generation of our youngsters has been brought up under a system of political philosophy as different from that of our fathers as a centipede is from Marilyn Monroe.

In 1840 Alexis de Tocqueville wrote "Every fresh generation is a new people." If this is true, what a responsibility each generation has for the one succeeding it. Here again we have a responsibility which collectively I do not believe we have been accepting. I refer to the deterioration of our public school system. No longer is it fashionable to make people study. John Dewey once made the obvious statement that children do best what they like to do. It did not take a profound philosopher to make that observation. "Progressive education" perverted his statement to make it read that students should not be forced to do what they do not want to do. That has resulted in the elimination of most of the "meaty" worth while courses from our public school curricula and the substitution of such silly froth as courses in "Life Adjustment," "How to Pick Up a Handkerchief Gracefully," or "How to Behave On a Date." This change probably accounts for the decrease in the number and quality of the applicants for our medical schools. Sound education no longer counts. There now is a tendency, however, to abandon such piffle and utter tripe and get back to the realities of education. It is a hard struggle, though, against the degeneracy of our times.

How can we expect to retrieve ourselves when we find a more or less complacent attitude taken towards professors who engage in rigged and false television programs? A professor is a man who is dedicated to "profess." What he is pledged to profess is the truth as he sees it. Yet, when one such false professor testified before a congressional committee, five of the nine members of the

committee complimented him and expressed their "appreciation." The chairman of the committee lauded him and predicted "a great future for him." Some of his students defended him. Have we not come to a pretty pass when congressmen and college students do not know the difference between right and wrong? There are certain truths which are self evident—the eternal verities —which men do not create, but which are found in the very nature of things.

Another evidence of our deterioration is the resistance on the part of some of our universities to having students, who accept federal scholarships, take the loyalty oath. Communists have been discovered as being the beneficiaries of some of these scholarships. If they had taken the loyalty oath, their scholarships could be discontinued; if not, they cannot be, so the lawyers say. What could possibly be the objection to anybody acknowledging his fealty to his country? If he does object, he should be relegated to the limbo of the never-never land where the woodbine twineth and the whangdoodle mourneth for its firstborn.

This new philosophy has led us to lead the soft life, to avoid competition and toil, to seek "security," to avoid competition—in short, to do everything that is in contrast to the characteristics of early Americans. The early American was independent—not dependent. He wanted only a chance to compete and to make good. Individual Americans did make good and they also made the greatest country that the sun has ever shown upon. What has happened to us in the last 25 years? The answer is that we have lost our spiritual values and our moral values.

No responsible legislator and no statesman would think of continually building up the public debt, as our miserable politicians have done during the last 25 years. A recent statement from the Director of the Budget[7] points out that our national debt is not a mere 290 billion dollars as most of us think it is. On the contrary, it is 290 billion of current public debt, plus 350 billion of future obligations for past services, plus 98 billion of C.O.D.'s. These figures add up to the almost incredible total of 750 billion dollars. That is our government's mortgage on our future, and this in addition to the regular annual cost of defense and "welfare." Welfare for whom?—welfare for the non-thrifty parasites, for the leeches who are sucking our country's lifeblood.

This tremendous public debt results in inflation, which is getting worse all the time, and which, unless it is stopped, will destroy our country. Besides its ruinous financial result, inflation leads to a form of moral degeneration, which has its effect on the people of the country, on families, and on the self discipline which we all like to see in our children.

There have been White House Conferences on Children and Youths, where people from all over the country gathered to discuss how our children could "realize their full potential for a creative life in freedom and dignity." It is high time that something was done about our youth when we note all the juvenile delinquency in the country, and hear of students who employ "ghosts" to prepare their theses. Does a White House Conference do anything about it? It only results in a lot of silly talk by well meaning, but theoretical ineffectuals, who will do nothing but spend more of our money to no purpose. The only way we can improve our youth is to give them the proper parents and the proper training. We cannot change their parents. If they have the proper parents, they will get the proper training. If they do not, we can at least expose them to education, a large part of which should consist in learning, not "life adjustment" or other silly froth, but something of the history of our country and what made it great. How many of them know that George Washington arose in the Virginia Assembly and said, "I will raise a thousand men from my private purse to go to the relief of Boston." If they read it now, with their present indoctrination against everything worth while, they would probably say that he was bragging about his wealth and trying to make a hero of himself. All who study the character of that Great Man know that his modesty was proverbial. Not many years earlier, when he had saved the remnant of Braddock's army after that pompous general's disastrous defeat, he had come to the Virginia Assembly to receive the thanks of the Colony for his heroic efforts. On rising to reply to the message of thanks, he was so overcome with confusion that the President of the Assembly said to him, "Pray sit down, Colonel Washington, your modesty is equal to your courage."

Youngsters today, who do not appreciate the moral and spiritual values of the founders of our country, are being denied their birthright. Instead, they are being taught that private property

is evil and that the capitalistic system is outmoded. Many of them probably think that Patrick Henry was an Irish patriot. They cannot know, unless they have read his life, how Benjamin Franklin felt when he said so simply and so eloquently, "Where Liberty dwells, there is my country." Nor can they know how John Adams felt, when on his death bed on the Fourth of July 1826, on hearing a salute of cannon in celebration of the occasion, he aroused himself long enough to murmur, "Independence forever!" These inspiring examples are part of our heritage. If they are not enough to make our children "realize their full potential for a creative life in freedom and dignity," what is? The trend of the times is to teach blasé youngsters that the old values are outmoded. They must be prepared for life in the brave new world, and, in my opinion, no socialist has the remotest conception of what bravery really is. He is not brave enough to engage in the struggle for existence, but wants life handed to him from the cradle to the grave, on a silver platter.

Our Obligation

What can we do about it? Unfortunately, most doctors do not do anything about it. That is a reflection on our profession. If we are, as Robert Louis Stevenson said, the cream of our civilization, then we have a high moral obligation. The fact that a doctor is busy does not relieve him of public responsibility. Every citizen's first duty is to his country. His duty to his business or his profession is secondary, even in the medical profession. That responsibility cannot be shirked, and it is more weighty in a democracy than in any other form of government. Remember that freedom is not static. It constantly has to be fought for. If we do not take our part in public affairs, we will be trampled on by the rabble.

I will close with an admonition uttered 60 years ago by that great patriot, inspiring leader, and rugged individualist, Theodore Roosevelt:

"I preach to you, my countrymen, that our country calls not for the life of ease, but the life of strenuous endeavor. The twentieth century looms before us big with the fate of many nations.

"If we stand idly by . . . if we shrink from the hard contests where men must win at hazard of their lives and at the risk of all they hold dear, then the bolder and stronger peoples will pass us by, and will win for themselves the domination of the world."

God forbid that that should happen! If it does happen, each of us must share our part of the responsibility for it.

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VOLUME XLVII
NUMBER 8

Doctors, Charity and Liberty

H. PHILLIP HAMPTON, M.D.
TAMPA

We hear much these days about medical care and welfare—the costs of medical care and providing care for the elderly and needy sick—the danger of government-financed medical care and "socialized medicine."

To understand better the problems of today, we must have a knowledge of the past and how it brought the present into being. I propose to trace in outline the origin of physicians and their charitable ministrations to the poor, the development of government interest in health services and the position of medical care in the ideological conflict of this century.

Origins of Medical Care for the Poor

The concept that disease and epidemics are divine judgment and the doctrine that cleanliness is next to godliness linked medical and religious practices in antiquity. Medical care as a distinct service was provided in ancient Greece by the disciples of Hippocrates. These physicians were largely itinerant practitioners who were renowned for their high standard of devotion to duty and who often "made no distinction between rich or poor, free or slave."

About 600 B.C., individual Grecian cities began to appoint permanent physicians who were paid a basic salary to care for the poor. In addition, they accepted fees for services to others.

Provision of a sanitary water supply by way of aqueducts and development of the public bath were the great hygienic contributions of the Roman Empire. Physicians practicing in conjunction with the public bath became concerned with matters of public health and thereby attained the status of urban officials.

During the Dark Ages, monasteries were left as the last refuge of learning and under the influence of Christian benevolent motives, they often created hospitals for the sick and poor, especially at the time of epidemics.

With increasing industrialization, urbanization and population, pestilence and disease became greater problems. With more enlightenment as to the cause and prevention of disease, urban government in Europe became concerned with matters of health.

Under the influence of such admonitions as "illness and untimely death are a waste of human resources" and "the health of the people is extremely important to the community, so that it cannot be left to the uncertainty of individual initiative" cities began to aid in the establishment of hospitals and to employ physicians to care for the sick poor.

In the early seventeenth century during the time of Elizabeth I, a Poor Law was established in England which charged the individual parishes with the responsibility of providing for the health and welfare of the poor. The poor, who were a large percentage of the population, thereby became indigent to their parish and lost their means of existence if they moved away. As industrialization increased, it became necessary in the eighteenth century to amend and nationalize the Poor Law of England in order to mobilize the industrial working force composed largely of the poor. This action set the stage for a tragic chapter in human relations in which the national government miserably provided welfare for the poor worker and industry exploited cheap labor.

Influence of Marxist Doctrines on Medical Care

It was in this setting of the nineteenth century that the communist manifesto was written which was destined to put a new and sinister emphasis on medical care for the poor or masses.

The Marxist doctrine advocates the violent overthrow of all governments based on individual ownership of property and the establishment of a dictatorship of workers as a government upon which the individual is completely dependent for all services, medical care, welfare and opportunity for work.

This socialist scheme to distribute better the material things of this world took various forms in Europe leading to Fabianism in England, communism in Russia, and various socialist dictatorships elsewhere.

Chairman, Council on Legislation and Public Agencies, Florida Medical Association.

Read before the American Public Health Association at its Annual Meeting, San Francisco, Calif., Nov. 1, 1960.

After World War I the International Labor Organization with representatives from the governments of the world was formed for the purpose of alleviating 'conditions of labor involving social injustice, hardship and privation,' adopting the doctrine that freedom *from* want and freedom *from* fear are rights of the individual and together with social security and health services are an obligation of the government to its citizens.

During the period of socialist development in Europe, there was a massive migration of Europeans to the United States. They were attracted to the opportunities under a government founded on a constitution that would protect the individual against all arbitrary coercion and that guaranteed certain rights to its individual citizens, among these the freedom *to* speak, *to* vote, *to* work, and *to* worship.

Development of Medical Care for the Poor in United States

With the establishment of government in the United States, the principle of the original Elizabethan Poor Law was adopted, and the individual counties were charged by the state constitutions with the responsibility of providing for those inhabitants who by reason of age, infirmity, or misfortune may have claims upon the aid and sympathy of society.

For two centuries the principle of local responsibility for the medical care of the needy sick or indigent of the community has worked well in many rural communities of this country, and the local physician often has assumed the responsibility in the Hippocratic tradition to provide medical care for the needy sick. In urban and industrial areas, however, the problems and cost of medical care for the needy sick have usually overwhelmed the resources of the local government and local physician. Several states, therefore, began to aid local communities in providing sustenance and medical care for the needy sick, motivated, no doubt, by Christian benevolent principles and the reasonable economy of preserving human resources.

As the doctrines of socialist revolution found little favor with the American voter, the tactics of the various organizations striving for socialization of the United States were changed to the device of encroaching government control. A major avenue of approach was through welfare programs providing medical services, ultimately leading to a government-administered compulsory health plan for all citizens— a prerequisite for complete socialization.

During a major economic depression, in 1935, the Congress of the United States enacted the national welfare laws as part of the social security system. Federal funds were made available to match state funds to provide sustenance and medical care to certain categories of citizens without sufficient personal resources to provide these needs for themselves. If the states chose to use these funds by providing matching state funds, vendors of medical care would be paid from the funds according to the requirements of the government welfare agency, and federal regulations required that these services would be equally available in all subdivisions of the state. Thus, the counties were relieved of the responsibility of providing for these categories of the poor or needy sick, and nationalization of the Elizabethan Poor Law was partially accomplished in the United States.

Medical Care for the Needy Sick in Florida

In the state of Florida, however, each individual county provided medical care for the needy sick of that county without state or federal aid in 1950, although adequate provisions were made for the care of tuberculous and psychotic Florida residents in state hospitals. There was a department of the State Board of Health in each county for statistical, sanitary, and hygienic purposes.

The physicians of Florida through their state medical association began a study of medical care given the needy sick and came to the following conclusions:

1. Medical care for the needy sick was inadequate in many counties.
2. Counties with inadequate facilities did not fully utilize or support adequate medical facilities in neighboring counties.
3. Voluntary hospitals were insufficiently compensated for hospital care provided needy sick indigent of the county.
4. Medical care for the needy sick was provided almost entirely by voluntary physicians without compensation.

The doctors recommended a continuation of the policy of not compensating physicians for medical care provided the needy sick, but deplored inadequate payment of hospital costs for these indigent, for the hospital costs of responsible sick persons paying their own hospital bills were of necessity increased and thereby a hidden tax on illness was imposed.

As a result of these recommendations, the Florida legislature created a state fund which each county could voluntarily match on a per capita basis to pay hospitals the cost of providing care for the needy sick requiring short term hospital care. This plan has worked well in providing hospital care for those in need, compensation to hospitals for the costs of care given, and aid to the counties in fulfilling their responsibilities to the needy sick. Recent amendments to the law permit these funds to be used for outpatient medical care and ancillary medical services at home to provide comprehensive medical care.

The program is administered under the State Board of Health, but the major financial and administrative responsibility remains with the county government. On the basis of population there is 98 per cent voluntary county participation.

The Florida legislature in 1959 chose to use federal funds available to match the state funds spent in hospital care of those needy sick who were public assistance recipients (about 50 per cent of those hospitalized under this program) in the hope that it would reduce the amount of state appropriation needed. Federal regulations did not permit use of county funds on a voluntary basis to participate in this matching program. In effect, therefore, the counties were relieved by the state and federal government of their constitutional responsibility in the care of these needy sick. County control and financial responsibility no longer applied to the public assistance recipient part of the Florida Hospital Service for the needy sick, and the state was recently called upon for additional funds to meet the costs of the rapidly expanding state and federal program. Additional state funds were not required, however, in the state and county part of the hospital program in which counties retained major responsibility.

Political Implications of Federal Welfare Medical Plans

County tax sources are frequently overburdened in providing necessary welfare programs and are in need of state and federal financial assistance, but relieving the county entirely of financial and administrative responsibility will improve *neither* the quality *nor* the economy of medical care given the needy sick. Such centralization of welfare programs, however, *will* increase their socialization potential.

An emotionally appealing issue in the program of encroaching socialism was presented to the recent Congress during an election year, as has been the custom during the past 30 years. The issue was to provide hospital care for all elder citizens through a program administered by the federal government and financed by a compulsory federal tax. This plan would have set the pattern which, through simple amendments, would design compulsory federally administered comprehensive medical care for *all* citizens—a major objective of the strategists for encroaching socialism.

The Congress wisely chose to reject this approach, but, mindful of the real need to aid the elderly sick whose retirement incomes have been tragically reduced by inflation, the Eighty-Sixth Congress enacted legislation to provide liberal matching funds to states for comprehensive medical care programs for the aged with insufficient resources to provide adequately for themselves.

Unfortunately, the same regulation that medical care must be equally applicable in all subdivisions of the state makes it most difficult to retain some county responsibility for care of these needy sick. We hope, however, to achieve this objective and provide a good comprehensive medical care program for the aged needy sick in Florida by a joint county, state and federal government matching fund from which vendors of medical care would be paid upon submission of approved vouchers for services rendered these needy sick. It is my estimation that an average annual expenditure of $1 per capita by the counties and appropriation of $1 per capita by the state with federal matching would supply sufficient funds to pay all vendors of comprehensive medical care for all needy sick 65 years of age and over, all public assistance recipients, and other needy sick of all ages. More than this amount is now budgeted and being spent by the state and the counties for these purposes. If the expenditure of these funds is coordinated under existing state law, an average of 66 per cent reimbursement is available in Florida from federal funds provided recently by the Eighty-Sixth Congress to aid in the care of the aged needy sick.

Liberal and Charitable

Another regulation concerning expenditures of federal funds for public assistance recipients requires administration of all funds by the same state agency, both funds for sustenance and funds for medical care. Thus medical care for this segment of the population is made a part of the welfare program and divorced from the usual agencies concerned with medical care of those who provide for themselves. Even in the federal department of Health, Education, and Welfare these

major multimillion dollar health projects are administered under the section of Welfare.

Medical care is a personal service rendered by one individual to another, and when the costs are paid by yet a third party, especially the government, the probability of abuse is great, unless at least one of the individuals involved feels responsible for the efficiency and economy of the service.

Through the centuries, physicians have been leaders in movements to provide better medical care for the needy sick and traditionally have given their medical services without charge. More recently, social welfare workers have taken the initiative in proposing plans to provide medical care for the aged, disabled and sick. Physicians are now considered ultraconservative with a social philosophy "anchored in the ice ages" while those in welfare are called radical. Although no doubt physicians have recently been preoccupied with scientific and technical advances in medical care to the detriment of their traditional social consciousness, I am sure the major opposition to national health schemes has been their grounded suspicion that these schemes were at least partially motivated by those promoting the Marxist doctrines designed ultimately to destroy individual freedom.

If nothing else, physicians are paragons of individual freedom. Although there are undoubtedly many instances of abuses of that freedom and neglect of social responsibility, if allowed to go his own way, the physician will serve the rest of us better than under any orders we know how to give.

Traditionally, physicians have given their services to the poor. Through those services they have built a medical educational system and promoted advances in medical care which have achieved for this country the finest state of health of any nation in the history of mankind.

The grace of charity reached the highest degree of application in our country. Charity has been a traditional and integral part of the practice of medicine. To convert the fruits of charity to a right of freedom from want by means of a compulsory tax for that purpose must of necessity abridge the liberty of those so taxed and create indigency upon the government as an accepted way of life. Care of the poor is a measure of civilization, but indigency must be recognized as a disease of our economy, destructive of freedom, palliated by charity, but not cured by calling it right. If charity goes, there is little hope but faith will follow.

The physicians of Florida have not accepted the proposition of government fees paid them as vendors of medical care to public assistance recipients, but have chosen to continue giving their services without charge to those unable to pay. They have established the Florida Medical Foundation through which physicians may give organized medical care to needy sick both in hospitals and as outpatients and exercise a responsibility for both the efficiency and economy of the service.

Now is the opportune time for physicians, social welfare workers and government officials at the county, state and federal levels to cooperate in establishing a comprehensive medical care program for the aged needy sick, maintaining county financial responsibility with state and federal aid and enabling organized physician administrative responsibility for economy and efficiency of operation through established channels of medical care.

Industry, labor, business and individuals should be expected to provide the means for medical care of their workers continuing into retirement. Physicians must bear the major responsibility for preventing abuses of medical care. Government must restrain itself from excessive regulation and standardization, to permit the opportunity of novel approaches to varying problems in medical care so that progress can continue under the process of natural selection.

Only in this manner can we achieve good medical care for all and prevent our government exchanging a guarantee of liberty for a guarantee of services. It is possible for a democracy to vote itself into bondage.

The problems of medical care provide today's pitched battle between the ideologies of government control of men, with the goal of security, and the ideology of government guarantee of individual liberty, with the goal of freedom.

The methods of providing medical care proposed here are not conservative but liberal—designed to maintain liberty and freedom of the individual. Socialist plans to turn everything over to the government are reactionary—advocating government control of the lives of men, a proposition dispelled by liberal documents from the Magna Carta to the Declaration of Independence.

Those who would have us live in a society like the ants and the bees may bury many free men, but the sovereign human force seeking freedom of opportunity to discover and interpret the order

of things will always be rekindled by adversity. We can only hope that today there are enough good men sufficiently enlightened to fight as hard to retain freedom while the opportunity is yet great.

1 Davis Boulevard.

ABSTRACTS

Screening Relatives of Diabetics in Five Florida Counties. By L. L. Parks, M.D., M.P.H., Quentin R. Remein, Lydia S. Shields, and James Turvaville. Pub. Health Rep. 75:55-59 (Jan.) 1960.

It has long been recognized that diabetes "runs" in families, but from the dearth of reports in the literature this knowledge apparently is seldom applied to community diabetes detection programs. Screening relatives of persons with diabetes is a continuing activity in Florida, and this report describes the detection project in Hillsborough, Jefferson, Madison, Suwannee and Taylor counties during the period January through June 1958. A total of 263 indigent persons with diabetes in these five counties named 935 relatives, of whom 452, or 48.3 per cent, were tested for diabetes. The rate of previously known cases of diabetes was 8.8 per thousand tested, and the yield of previously unknown cases of this disease was 22.1 per thousand tested. This yield is more than three times the usual yield in diabetes screening programs in general population groups. While the number of diabetic persons found was small, the results support previous findings that this is a practical case-finding method with a high rate of yield.

Nuclear Mass and Allied Phenomena in Adenocarcinoma of the Colon. By Robert Gutman, B.S., and Alvan G. Foraker, M.D. Am. J. Clin. Path. 32:436-441 (Nov.) 1959.

In the study described in this article, interference contrast microscopy was applied to the determination of nuclear mass in adenocarcinoma and normal mucosa of the colon. This new method of cell study permits estimation of dry mass (with allied phenomena) of objects in the microscopic field. The basic principle is that of refractometry. In initiating this study of cellular changes in transition from normal mucosa to carcinoma of the colon, 10 examples of adenocarcinoma were examined by means of interference microscopy and planimetry. Comparisons between normal mucosa and adenocarcinoma revealed: (1) carcinoma nuclei were heavier and larger than normal nuclei; (2) carcinomatous epithelium in a standard sample had greater nuclear concentration and a greater weight of nuclear material than did normal epithelium; and (3) no differences between normal and carcinoma-cell nuclei were observed on determinations which reflect protein molecular concentration within the nuclei, including refractive index, total particle thickness, and dry mass per unit area. The authors report that they expect to study the full range of changes from normal colonic mucosa to invasive carcinoma by means of special cytophysical and cytochemical methods.

Unusual but Uncomplicated Peptic Ulcers. By Donald F. Marion, M.D. Am. J. Digest. Dis. 4:921-928 (Nov.) 1959.

The author discusses esophageal ulcer, cardioesophageal ulcer, pyloric-channel ulcer, postbulbar ulcer, and ulcer in diverticula and points out that the existence of these unusual forms of peptic ulcer must be kept in mind if there is to be improvement upon the present poor diagnostic performance. Better radiologic techniques, the expenditure of more time and film, and a willingness to perform repeated examinations are all especially important when recurrent gastrointestinal bleeding remains unexplained. More endoscopic studies may lead eventually to a larger body of skill and experience which will have a constructive effect. In connection with the establishment of a frequently encountered clinical picture which may characterize these rarer ulcers, physicians have an obligation. A recurrent symptom complex may well become documented in time for although it may seem somewhat old fashioned, critical analysis of subjective symptoms still constitutes a valuable tool for research.

Recognition of the limitations of medical treatment, particularly in pyloric and postbulbar ulcers, leads to the surgical approach and raises the question of different and less drastic surgical

procedures which may provide excellent results if they are employed before extensive pathologic changes have taken place. Concerning gastric ulcer, it is suggested that longer periods of bed rest would make a great difference, both in rapidity of healing and in prevention of early recurrences. In common with all peptic ulcers, the unusual and less frequently encountered ones of special interest require specific knowledge of individual secretory capacity for optimum therapy, particularly in respect to surgical treatment. Gastric analysis, so long overshadowed by x-ray as a diagnostic tool and a means of reasonably accurate prognosis, has regained its once paramount position. Together with saline lavage and cytologic analysis of exfoliated epithelium, improved methods of estimating gastric secretion have restored the gastric tube to its former state of indispensability.

Dexamethasone in Dermatologic Therapy. Study of Case Reports. By Perry A. Sperber, M.D., F.A.C.A. Ann. Allergy 17:895-900 (Nov.-Dec.) 1959.

Dexamethasone is the latest cortisone analogue to be made available for therapeutic use, and the claim is made for this steroid that it is more potent than its predecessors. A study was made to determine the effectiveness of this drug in various dermatologic diseases. When administered orally, dexamethasone was found to be an effective anti-inflammatory agent in the treatment of various dermatologic disorders such as contact dermatitis, atopic dermatitis, erythema multiforme, urticaria, and intertrigo. It was ineffective in one case of scleroderma. No undesirable side effects of serious import were noticed. Dexamethasone was also an effective anti-inflammatory agent when used topically in second degree burns and lesions of contact dermatitis, atopic dermatitis, and intertrigo.

Surgical Treatment of Ruptured Aneurysm With Intracerebral and Subarachnoid Hemorrhage in a 16-Month-Old Infant. By Fariss D. Kimbell, Jr., M.D., Raeburn C. Llewellyn, M.D., and Homer D. Kirgis, M.D. J. Neurosurg. 17:331-332 (March) 1960.

A survey of the literature indicates that intracerebral or subarachnoid hemorrhage in infants and children occurs rarely and that in most cases reported the source of the hemorrhage was not determined or it was secondary to some type of arteriovenous anomaly. The authors present a case in which angiography demonstrated a small aneurysm on the ascending parietal branch of the middle cerebral artery in a 16 month old male infant. Craniotomy was performed at once and the aneurysm was excised without difficulty. Recovery followed with only minimal neurologic residuals which constitute no disability or discomfort. The authors believe this infant is the youngest patient who has been treated successfully by surgical excision of the aneurysm following the development of an intracerebral and subarachnoid hemorrhage from rupture of the aneurysm.

Stool Examinations in General Practice. By H. B. Goodwin, Jr., M.D. South. M. J. 53:1173-1175 (Sept.) 1960.

The author analyzes a series of 1,193 stool examinations, and comments at the outset that the most helpful knowledge is to know when to examine a patient's stool. If the patient is anemic, has an eosinophilia, has a "pasty" color, and is without a history of allergy, a routine stool examination seems indicated. Most of the patients were asymptomatic. It was, in fact, the purpose of the study not to include patients having symptoms but to use those in whom one would normally not check the stool for parasites. Tables indicate the classification of intestinal parasites, both protozoa and nematodes, the sex and race incidence, the incidence in age groups, and the incidence of various pathogens in the series. The method of stool collection is described, and comment is made on treatment. It is noteworthy that from 1954 through 1958 in the Florida State Board of Health Laboratories 666,688 stool examinations were made; 20.4 per cent gave positive results for one or more parasites. Hookworms were found in 12 per cent and roundworms in 4.4 per cent, with other types in proportion. Thus, in one of every five stools examined the result was positive for intestinal parasites.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

PRESIDENT'S PAGE

O Tempora, O Mores

Present day American physicians, if we are to enhance our public image, improve our political standing, and maintain our peerless scientific reputation, will have to abandon our traditional aloofness and our customary lethargy. Otherwise, those forces which we consider evil will overcome us by default.

It is not enough that we shall practice good medicine, giving of our time and talents to the indigent and caring for our patients. Through necessity to preserve a way of life and a system of practice, we must be political contortionists with a shoulder to the wheel, an eye to the future, an ear to the ground, a finger on the public pulse, and a nose to the grindstone—but no head in the clouds.

The Public Relations and Legislative Committee of the Polk County Medical Association reports a recent constructive conference with its Congressman Haley. He pointed out that it is difficult for the doctor to maintain his favorable position publicly because of the adverse propaganda put out by labor groups to create the impression that the doctor is rich in money and short in charity. He called on organized medicine to correct this misrepresentation and to defend our position as a profession that serves the people, that is continuously engaged in charity work, that is vitally interested in the health of the aged and regularly contributes time and money to this without compensation or recognition.

Congressman Haley further charged the medical profession as well as many other groups in our society with wishing and hoping for results in government but not being willing to work actively for those ends they seek. He stated that if the conservative cause, the freedom of the human soul, and the integrity of the Constitution of the United States are to be maintained, we must contribute our time, efforts and money to all levels of political action at our city, county, state and national levels.

One of the most effective levels for activity for all Florida physicians will be in the forthcoming session of the Florida legislature. The Legislative Committee of your Association has prepared proposed revisions of the so-called Medical Practice Act. In addition, the Legislative Committee on Health and Welfare of the Florida House of Representatives requested the State Board of Health and the State Welfare Board to evolve recommendations for legislation for indigent medical care in consultation with the Florida Hospital Association, the Florida Medical Association and other groups.

When the Association's policy is determined, it will be forwarded to each component medical society, and each member will be urged to participate in promoting the passage of this legislation.

On the national scene, continue to write your congressman and senators that they have no doubts as to your feelings about specific legislation or the tenor of your principles.

YCDBSOYA

Leo M. Wachtel

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Bananas — A Remarkable Nutrient

Bananas, one of the first fruits cultivated by man, bear the botanical name "Musa sapientum," attributed by the philosopher Pliny to the fact "that sages reposed beneath its shade and ate of its fruit." First used medicinally by the ancient Chinese, the banana has been widely accepted in more recent decades in the treatment of celiac disease, peptic ulcer and constipation.

An average small banana contains about 100 calories (carbohydrate) and is advocated by proponents of dieting to lose or to gain weight, according to the individual's need. One medium banana contains 630 mg. of potassium and 1 mg. of sodium. This has its obvious advantages in patients with edema or those with depleted potassium reserves. Patients receiving diuretic therapy for hypertension or edema should receive from 2 to 6 Gm. of potassium a day if their kidney function is normal, and two or three bananas can supply a sizable percentage of this need.

It has become apparent that bananas contain large amounts of serotonin and catechol amines. Serotonin is one of the biologically active amines whose breakdown is prevented by the monamine oxidase inhibitors, a class of new drugs which are currently used in the treatment of psychic depression, angina pectoris, hypertension and rheumatoid arthritis. It has been postulated that a high level of serotonin in the brain is desirable for the prevention of mental depression. "Few suspected that the ingestion of this decorator of breakfast cereal might significantly aid the control of their mental hemeostasis, or perhaps even compete with the analyst's couch at 5 cents a throw."[1] Perhaps the sages after whom the banana was named were wiser than we moderns who regard fish as "brain food."

The most practical significance of this recently acquired information is that the ingestion of bananas in normal persons will give a false positive test for 5-hydroxyindoleacetic acid (5-HIAA) in the urine in those patients where the test is being run to diagnose malignant carcinoid metastatic to the liver and in whom the serotonin produced by the tumor is converted into 5-HIAA which is excreted via the kidneys. Likewise, a false positive test for catechol amines will result if a patient being tested for pheochromocytoma

has been eating bananas. Obviously, patients being tested for these conditions should be on a banana-free diet for several days prior to collection of the urine specimens.

JACK FLEMING, M.D.
PENSACOLA

1. Editorial: Whence Bananas and Whither? New England J. Med. 261:47-48 (July 2) 1959.

Operation KISS

This editorial, written during the Christmas season of peace and good will, and published in the month of February with its Valentine celebration, might well be supposed to concern itself with kissing and courting. These are commendable and enjoyable pastimes which need no additional comment here.

Actually, Operation KISS is one of a multitude of Projects and Operations bearing strange and often nondescriptive names which have originated in Washington and more especially the Pentagon. Operation KISS is perhaps unique among them in that it has direct application to each of us and to our businesses or professions, although it should reap its greatest benefits in the bureaucratic system of state and federal government.

Operation KISS is an easily remembered abbreviation for "Keep It Simple, Stupid." How delightful it would be if this advice were followed by those in the military, in the Congress, and in the Income Tax Department, among others. But we in the medical profession can also benefit by "keeping it simple." Instructions to patients are often lengthy and confusing; explanations to patients and their families may raise more questions than they answer; and poorly written orders on hospital charts all come to mind as areas which each of us might strive to improve.

Other areas which need noticeable improvement are "summaries" of case histories written to insurance companies or referring physicians, medical testimony in court, and above all the articles and editorials submitted for publication in the medical literature. Length or verbosity is no substitute for unadorned facts presented in a straightforward manner.

Keep It Simple, Stupid—Operation KISS—is a good motto to hang on your wall.

J.M.P.

Scientific Program 1961 Annual Meeting

The Committee on Scientific Work of the Florida Medical Association met in Jacksonville on Dec. 11, 1960, to formulate final plans for the scientific program for the Eighty-Seventh Annual Meeting of your Association to be held in the Americana Hotel, Bal Harbour, Miami Beach, May 25-28, 1961.

The First Scientific Assembly is scheduled for Friday morning, May 26, and is planned as a presentation of two one hour diagnostic conferences. This portion of the program is being worked out by Dr. Franz H. Stewart of Miami, whose experience with similar clinical discussions will insure an outstanding conference presenting problems of interest to all members of the Association.

At 2 p.m. on Friday afternoon the Second Scientific Assembly will be held. This period will be devoted to the presentation of six papers, limited to 15 minutes each, prepared by members of the Florida Medical Association over the state. The discussion period following each paper will be informal, with the presiding officer on the rostrum moderating discussion from the floor. Five minutes will be allowed for each of the discussion periods.

The Third Scientific Assembly will occupy Saturday morning, May 27, and will feature the use of coordinated speakers, invited as joint guests of the Florida Medical Association and special interest groups. Participating in this program will be Dr. Charles A. Owen Jr. of the Mayo Clinic in Rochester, a guest of the Florida Academy of General Practice, who will discuss the general subject of radioactive materials and their clinical uses. Dr. Harold W. K. Dargeon, from the Memorial Center for Cancer and Allied Diseases, who will discuss chemotherapy of malignant diseases in children, has been invited in conjunction with the Florida Pediatric Society. Dr. Oscar Creech Jr. of Tulane University School of Medicine, New Orleans, a guest of the Florida Chapter of the American College of Surgeons, will discuss the perfusion therapy of cancer. It is planned following these three presentations to have a one hour panel discussion on what the future may hold for us in each of these fields.

Following a short intermission, Dr. Robert S. Hotchkiss, Professor and Chairman, Department of Urology, New York University College of Medicine, will discuss the kidney in hypertension as a guest of the Association and the Florida Urological Society. The last guest upon the morning program will be Dr. John Adriani, Professor of Anesthesiology, Tulane University School of Medicine, representing the Florida Society of Anesthesiologists and discussing anesthesiology and the hypertensive patient. Each of these guest speakers will be allowed 20 minutes to present his thoughts on his chosen subject.

This session will conclude the scientific presentation, allowing the special interest groups to hold their meetings upon Saturday afternoon and Sunday morning. Throughout the entire meeting, the scientific exhibits, technical exhibits and what is hoped will be the largest hobby display ever presented before the Florida Medical Association will be open, and we urge that you visit this exhibition area whenever time permits. If you should have a hobby or wish to present a scientific exhibit at this meeting, please contact



A beach in the Miami area.



The pool and an exterior view of the Americana Hotel.

FLORIDA MEDICAL ASSOCIATION

	Thursday, May 25	Friday, May 26	Saturday, May 27	Sunday, May 28
MORNING	Scientific Film Program **Registration** **11:00** Visit Exhibits	**First Scientific Assembly** *Diagnostic Clinics* 9:00 - 10:00 10:00 - 11:00 *Reference Committee Meetings* **General Session**	**Third Scientific Assembly** 9:00 Address 9:20 " 9:40 " Recess to visit exhibits 10:10 - 11:10 Panel Recess to visit exhibits 11:20 Address 11:40 "	**Specialty Groups**
AFTERNOON	**House of Delegates** First Meeting 1:00 Delegates' Registration 1:30 House in Session Annual Meeting, Blue Shield	**Second Scientific Assembly** 2:00 Address 2:20 " 2:40 " Recess to visit exhibits 3:15 Address 3:35 " 3:55 "	**Specialty Groups**	**House of Delegates** Second Meeting 1:00 Delegates' Registration 1:30 House in Session
EVENING	Alumni Affairs	President's Reception	Specialty Group's Socials	

your Committee and present your plans for consideration.

Upon Thursday morning during the time of registration, because two medical films of special interest to the entire association are available, these will be presented in the main amphitheater for your viewing.

Plan now to arrive early, to attend the scientific assemblies, to visit the exhibits of the 1961 meeting of the Florida Medical Association.

Thad Moseley, M.D., Chairman
Committee on Scientific Work

Florida Physician Prepares Outstanding Motion Picture

Dr. G. Dekle Taylor of Jacksonville has prepared an unusual and most instructive film of great permanent value which is evoking wide interest. This completely factual presentation of man's mastery of a marine environment is reviewed on page 2239 of the December 31, 1960, issue of the Journal of the American Medical Association as follows:

Man Returns to the Sea: 16 mm., color, sound, showing time 27 minutes. Prepared by G. Dekle Taylor, M.D., Jacksonville, Fla. Produced in 1960 by Russell Barton Film Co., Jacksonville, Fla. Procurable on loan ($3.00) from American Medical Association, Motion Picture Library, 535 North Dearborn St., Chicago 10, Ill.

This film is devoted to the thesis that man can overcome his natural handicaps in an aquatic environment by applying his knowledge of physiology to the invention of appropriate apparatus, and can thus return, at least on occasion, to the marine environment from which he is believed to have sprung. Its most valuable features are, first, a marvelous succession of action pictures of marine animals showing their ability to control their internal and external respiratory passages, and to protect their ears and eyes, and second, some diagrams illustrating the unexpected effects of pressure changes, especially upon the ear. Outstanding among the pictures illustrating comparative physiology are those showing how the alligator can open his mouth without exposing the passage into his pharynx, and how the pelican controls the opening from his mouth into his respiratory passages. The diagrams of the human ear show the complicated physics involved in the insertion of an ear plug and the mishaps that can result from ear plugs used in the wrong situation. It is an instructive film of immense permanent value because it is completely free from any theorizing and because it brings together so much material that could hardly be assembled again except at the expenditure of much time and money. The film should interest a wide variety of audiences, as it is completely factual. It brings together a variety of phenomena that would be extremely difficult to produce in a laboratory and could not be seen by a zoologist or a traveler unless he spent an extraordinary amount of time visiting aquaria, carnivals and the haunts of skin divers. Special mention should be made of the action photographs of divers eating and drinking under water. The phenomena are there to be enjoyed superficially by audiences of any age, but would be appreciated more deeply by those with a knowledge of anatomy and physiology. For advanced classes, these things can be explained later by a teacher prepared to go into detail about the fine control of the tongue, soft palate, posterior nares, and glottis, that makes such remarkable performances possible. The quality of the photography in this motion picture is very good, and the narration is evenly paced for clear understanding. The film therefore can be shown to advantage to any audience, young or old, scientific or not. It is highly recommended for showing to skin diving clubs, swimming groups, scout groups, and anyone interested in water sports.

University of Florida Medical Advisory Committee

Fifteen prominent Florida physicians have been appointed to the University of Florida's Medical Advisory Committee by University President J. Wayne Reitz.

The Committee serves in an advisory capacity to the President of the University on matters concerning medical education and other facets of the J. Hillis Miller Health Center. The Center includes the Colleges of Medicine, Nursing, Pharmacy, Health Related Services and the Teaching Hospital and Clinics.

Dr. William C. Thomas Sr., Gainesville, was named chairman. Dr. Clyde O. Anderson, St. Petersburg, is vice chairman.

Others named to the Committee include: Dr. Jere W. Annis, Lakeland; Dr. Turner Z. Cason, Jacksonville; Dr. Charles J. Collins, Orlando; Dr. James T. Cook, Marianna; Dr. Frederick K. Herpel, West Palm Beach; Dr. Edward Jelks,



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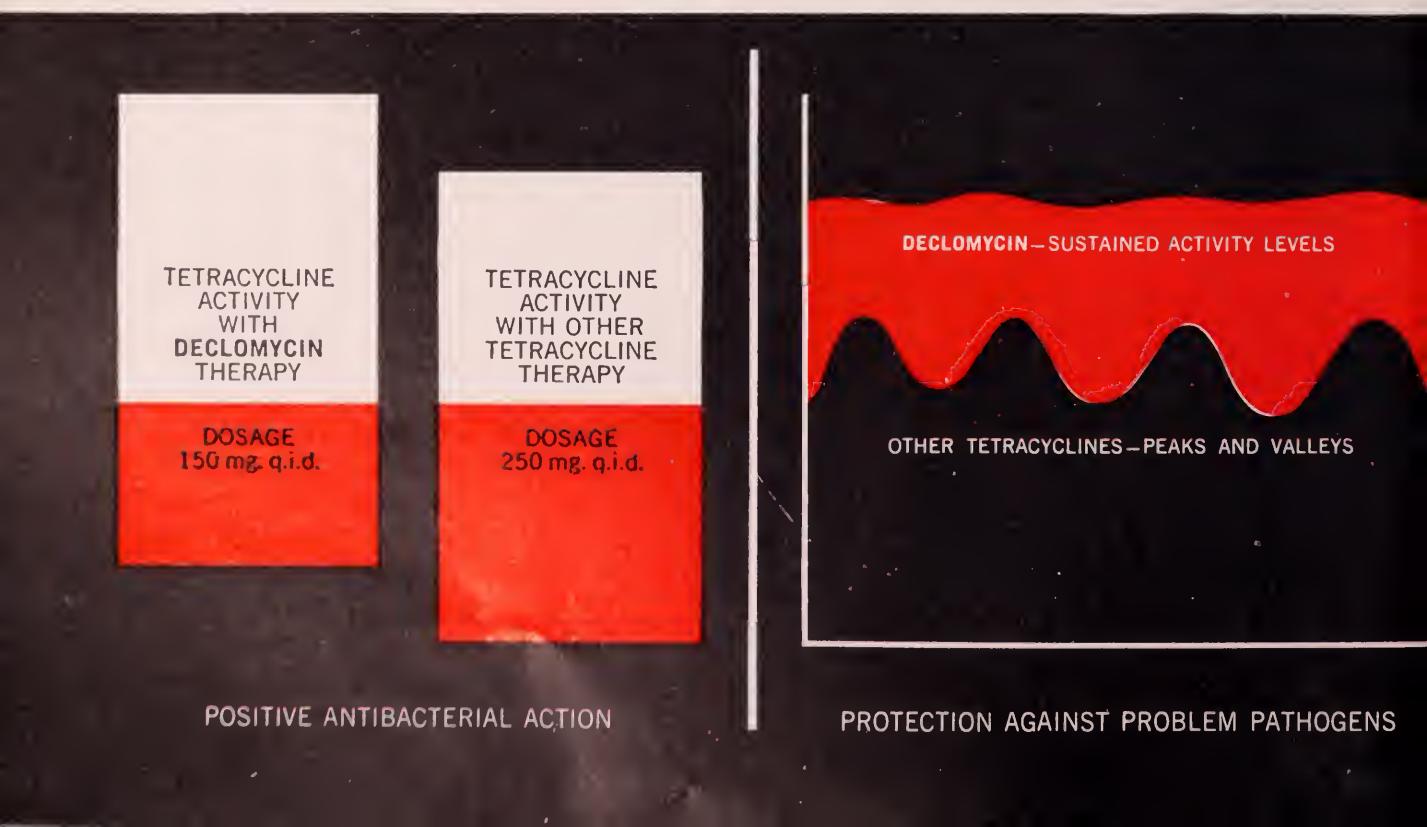
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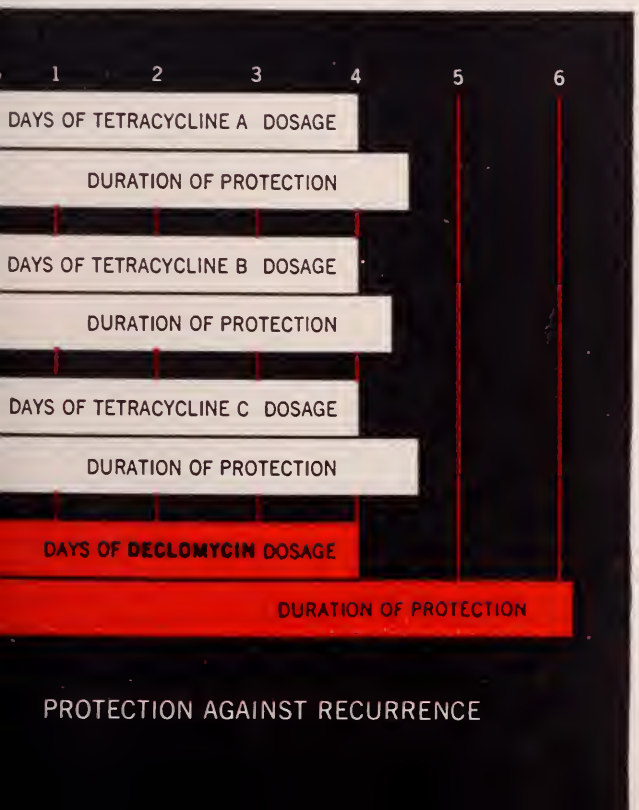


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CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

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Jacksonville; Dr. Norval M. Marr, St. Petersburg; Dr. David R. Murphey Jr., Tampa; Dr. Louis M. Orr, Orlando; Dr. Eugene G. Peek Sr., Ocala; Dr. William C. Roberts, Panama City; Dr. Donald W. Smith, Miami, and Dr. Henry M. Yonge, Pensacola.

American Urological Association Southeastern Section Meeting March 19-23, 1961

The Diplomat Hotel and Country Club, Hollywood-by-the-Sea, will be the scene of the 1961 annual meeting of the Southeastern Section of the American Urological Association, which is scheduled for March 19-23. Dr. N. Lewis Bosworth of Lexington, Ky., is president of this sectional group, and Dr. James L. Campbell of Orlando serves as secretary. The president-elect is Dr. Alfred D. Mason Jr. of Memphis, Tenn. Dr. Willard L. Fitzgerald of Miami, currently president of the Dade County Medical Association, heads the reception committee. Other Floridians serving on this committee are Dr. Jack A. Sloane of Miami and Dr. Robert J. Brown of Jacksonville. Mrs. Russell B. Carson of Fort Lauderdale will assist Dr. Fitzgerald by serving as chairman of the ladies entertainment committee.

Dr. Campbell, chairman of the program committee, directs special attention to a seminar of pediatric urological problems planned for Thursday morning, March 23. The pediatricians in the Miami area are cordially invited to attend this session. Papers will be read on recognition of vesical neck obstruction in children, prostatic valves in the newborn, renal cell carcinoma in children, the diagnosis and treatment of ureteral reflux in children, and urinary tract infections in female children.

Several members of the Florida Medical Association will appear on the program. Dr. Roy P. Finney Jr., of Tampa, has a gadget for sterilizing cystoscopic water in the office. Dr. Michael R. Blais, of Daytona Beach, will report a case of bilateral Wilms' tumor. Dr. Linus W. Hewit, of Tampa, will describe the Tampa General Hospital's demineralization setup for transurethral resections. Of special interest will be a paper given on lymphography, its role in detection and therapy of carcinoma and neoplastic obstruction of the genitourinary tract, by Drs. Manuel Viamonte Jr., Milton B. Myers, Manuel Soto and Norman Kenyon, all residents of the Jackson Memorial Hospital in Miami. Dr. Milton M. Coplan, of Miami, will discuss this paper. Dr. Benedict R. Harrow and Dr. Sloane, of Miami, will present a paper on retroperitoneal fibrosis. Dr. Melvin M. Simmons, of Sarasota, and Dr. Finney will each present a paper on prostatitis, and Dr. David W. Goddard, of Daytona Beach, will open the discussion of these papers.

Other Florida physicians who are serving this organization officially this year include: Dr. William A. VanNortwick, of Jacksonville, and his alternate, Dr. Hewit, executive committee; Dr. Goddard, national committeeman and golf committee; Dr. Perry D. Melvin, of Miami, arrangements committee; Dr. Russell B. Carson, of Fort Lauderdale, chairman, hotel committee; Dr. Frank M. Woods, of Miami, chairman, entertainment committee and member, budget and finance committee; Drs. Asher Hollander and S. Elliott Wilson, of Hollywood, co-chairmen, and Dr. John R. Browning, of Jacksonville, publicity committee; Dr. A. Fred Turner, of Orlando, scientific exhibits committee; Dr. Edwin W. Brown, of West Palm Beach, pyelogram hour and nominating committees; Dr. VanNortwick, chairman, motion picture committee; and Dr. Campbell, chairman, program committee and member, legislative committee.

Suncoast-Hillsborough Cardiovascular Seminar February 18-19, 1961

The Third Annual Suncoast and Hillsborough County Cardiovascular Seminar will be held on Saturday and Sunday, February 18 and 19, at the Soreno Hotel in St. Petersburg. The program will be presented from 9 a.m. to 4 p.m. each day. The Seminar is sponsored jointly by the Suncoast Heart Association of St. Petersburg and the Hillsborough County Heart Association of Tampa.

The guest speakers and their subjects are: Dr. Mark D. Altschule, Harvard Medical School, Boston, "Pulmonary Edema" and "Emotion and the Circulation;" Dr. Henry T. Bahnson, Johns Hopkins University School of Medicine, Baltimore, "Surgery of the Aorta and Aortic Valve" and "Surgery for Carotid and Renal Arterial Obstructions;" Dr. Charles K. Friedberg, Columbia

University College of Physicians and Surgeons, New York City, "Diagnosis of Coronary Heart Disease" and "Evaluation and Management of Hypertension;" Dr. Jack D. Myers, University of Pittsburgh School of Medicine, Pittsburgh, "Myocardial Versus Mechanical Factors in Heart Disease" and "Vagaries in the Clinical Picture of Arteriosclerosis;" Dr. Alexander S. Nadas, Harvard Medical School, Boston, "Recent Developments in Diagnosis and Treatment of Congenital Heart Disease" and "Management of Cardiac Arrhythmias in Infancy and Childhood;" and Dr. Oglesby Paul, University of Illinois College of Medicine, Chicago, and President of the American Heart Association, "Observations in a Long Term Study of Coronary Heart Disease" and "The Course of Congestive Heart Failure."

The two panel topics scheduled are "The Use and Abuse of New Drugs in the Treatment of Heart Disease" and "What Are Current and Projected Indications for Successful Cardiovascular Surgery?" Dr. Myers will moderate the first and Dr. Friedberg the second with the panel in each instance consisting of all the other speakers.

Obstetricians and Gynecologists Meet in Miami Beach April 21-28, 1961

The Tenth Annual Clinical Meeting of the American College of Obstetricians and Gynecologists will be held at the Americana Hotel, Bal Harbour, Miami Beach, the week of April 21-28. The president of this national organization is Dr. C. Paul Hodgkinson of Lathrup Village, Mich., and the president-elect is Dr. Nicholson J. Eastman of Baltimore. Dr. Ralph W. Jack of Miami is chairman of the committee on local arrangements, and Mrs. James H. Ferguson will assist him as chairman of the ladies entertainment committee.

This year for the first time postgraduate courses are included in the program. They are scheduled to begin on Friday, April 21, and continue through the following Sunday noon. The subjects selected for the five courses are: Genetics and Human Reproduction; Biostatistics; Radiation Physics; Parenteral Nutrition, Electrolyte and Fluid Balance; and Steroid Metabolism. Closed circuit medical television will be a second innovation at this meeting. Dr. James H. Ferguson and Dr. Oliver W. Davenport of Miami are arranging the clinical presentations which will make up these television programs, and Smith, Kline and French will handle the telecasting problems.

In addition to the general program, there will be 240 breakfast conferences, 92 one hour clinical conferences, and 9 four hour correlated seminars. Dr. W. A. D. Anderson of Miami will appear on the general program. Six other members of the Florida Medical Association will participate in the breakfast conferences: Drs. Joseph W. Scott and Carl H. Davis of Miami, Dr. James M. Ingram Jr. of Tampa, Drs. Jean B. Williams and J. Champneys Taylor of Jacksonville, and Dr. Harry Prystowsky of Gainesville. Drs. Ingram and Prystowsky will also participate in the clinical conferences.

American Academy of General Practice Miami Beach Meeting, April 17-20, 1961

What economic problems face medicine today and what will these problems be tomorrow? What is new in the diagnosis and treatment of cancer? What is the best way to deal with adolescents? These and countless other questions will be answered at the American Academy of General Practice Annual Scientific Assembly, April 17-20, in Miami Beach's Auditorium and Convention Hall.

The scientific program will feature more than 30 prominent physician-authorities. More than 100 scientific and 300 technical exhibits will be prepared for the 7,000 doctors and guests expected to attend. The Academy is the nation's second largest medical association and the only American medical group organized strictly for family doctors.

Mac F. Cahal, executive director of the 27,000 member organization, says the 1961 scientific program offers an exciting and valuable postgraduate education opportunity for physicians.

The Congress of Delegates, the Academy's policy-making body, will convene at 2 p.m., Saturday, April 15, in the Eden Roc Hotel. Delegates from each of the 50 states, Puerto Rico and the District of Columbia will meet until noon, Monday, April 17, when the scientific sessions open in the auditorium.

Of the more than 100 national medical associations, the Academy is the only one that requires its members to do continuing postgraduate study. Each member must complete 150 hours of accredited postgraduate study every three years. Only in this way, the Academy believes, can doctors learn about medicine's newest discoveries and techniques. For this reason, the Assembly plays a vital role in the Academy's study program. This year, subjects range from surgery and gynecology to cancer and ear problems.

Dr. Franklin J. Evans, Coral Gables, is chairman of the Local Arrangements Committee. Ladies' entertainment is under the direction of Mrs. Walter Glenn, Ft. Lauderdale.

The New Orleans Graduate Medical Assembly

The Twenty-Fourth Annual Meeting of The New Orleans Graduate Medical Assembly will be held March 6, 7, 8 and 9, 1961, with headquarters at the Roosevelt Hotel.

Nineteen outstanding guest speakers will participate, and their presentations will be of interest to both specialists and general practitioners. The program will include 57 informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposiums, medical motion pictures, round table luncheons, scientific exhibits and technical exhibits.

Following the meeting in New Orleans, arrangements have been made for a clinical tour to the Orient leaving New Orleans via air on March 10, to make connection with a Jet flight leaving Los Angeles at night. The itinerary includes visits to Hawaii, the Philippines, Hong Kong and Japan, returning on March 30 to the gateway city of choice—Los Angeles, San Francisco, or Seattle. Optional extensions may be arranged.

Details of the New Orleans meeting and the tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

The names of the guest speakers and their field of specialty were published in the November and December issues of The Journal. There is additional information in these issues which may be of interest.

OTHERS ARE SAYING

A Lesson From a Hurricane

In analysis of panic versus judgment, the writer became a victim of the former on report of an excitable woman following a telephone call by another. He was spending an October evening at the home of a long time acquaintance, when after answering the phone, the hostess announced that two sneak hurricanes were to meet within an hour over the Tampa Bay Area and were coming rapidly from the southeast and southwest simultaneously. Instead of considering the origin of the report and the remoteness of the possibility of one, much less two, coming so quickly, he rushed home to "batten down" storm awnings and fill the Coleman lantern, which in passing had been stored for fifteen years, not used at the last filling and did not work until the next morning in bright sunlight. With logical thinking returned, he went to bed as in like situations in years past and forgot storms which never came.

Too often the same hysterical reactions happen among us when some journalist writes about the short comings of the medical profession, because of the sale of the script for public appeal.

Although both hurricanes and bad medicine can be dangerous and warnings should be considered seriously, hysteria must be avoided. We can't do anything to stop the former but we have done excellently well to prevent the latter through organized medicine and scholastic training .

County Medical Societies really serve as warning services in reverse by accepting only qualified members and policing their memberships, should one waver from the straight and narrow.

This is done without fanfare. It is quite effective. The most individualistic member hesitates not to take censorship seriously and mend his ways to not be excluded from the fold. Further, the great majority are appreciative rather than resentful. Membership is a badge of distinction and identification to the public, probably too little appreciated while it exists but its loss becomes a serious stigma to the individual among his colleagues and patients.

We must be mighty careful to not get two hurricanes involved when one will do. That is why we have Mediation Committees, service on which is a thankless and often distasteful job. It

will function hand in glove when the Medico-legal Committee gets into full sway.

Whitman C. McConnell, M.D.
Picomeso Mail Bag
December 1959.

BLUE SHIELD

Facts That Figure

Today, in this country, the best of medical care and the finest in hospital facilities are available to essentially all persons, in all walks of life, at all times and wherever needed. It is understandable that such blessings are expensive, so much so that, for the most of us, they would be out of reach were it not for the modern miracle of prepayment against the expenses of illness. Normally, the major decision resolves itself into whether to be protected by the service type, community-rated Blue Shield and Blue Cross, or the indemnity type, experience-rated programs offered by commercial insurance companies.

How does one determine which is better? What is the prime factor to be considered by the procurer of this type of protection? One that stands out above all others, and one that is easily understood, is the percentage of return to the amount paid in. How much of the subscription dollar, or premium, comes back in benefits? A recent survey of companies writing over one million dollars annually in health insurance coverage in Florida brings to light some interesting information.[1]

The 12 commercial companies studied collected $51,367,925 in health benefits in the state during a 12 month period. Their direct losses (amount paid out in benefits) totaled $33,195,217 or 64.6 per cent. The premium income by company ranged from slightly better than $1,000,000 to more than $10,000,000, with the losses ranging from just over 50 per cent to 88.2 per cent. It is interesting to note that the company doing the largest dollar volume of business paid back the lowest percentage in benefits. This particular study does not reveal what proportion of the health protection was provided through group coverage, nor what percentage was available only in conjunction with life insurance.

How does this compare with the Blue Cross-Blue Shield record for the same period? During this same period Blue Shield and Blue Cross together returned to their subscribers $25,963,759 out of the $28,242,595 paid in through subscription fees, or 91.9 per cent. Blue Shield alone returned to its subscribers benefits totaling $8,190,838 out of the $9,120,515 paid in, for a percentage of 89.8.

The figures have spoken.

1. Data taken from the annual report of the Insurance Department, State of Florida, for the fiscal year ending June 30, 1960.

STATE NEWS ITEMS

Dr. Wiley M. Sams of Miami has been elected president of the American Academy of Dermatology and Syphilology. The choice of Dr. Sams took place during the 19th annual meeting of the Academy held in Chicago.

Dr. Hawley H. Seiler of Tampa was among the group of Florida physicians attending the annual meeting of the Southern Thoracic Surgical Association held the first of December in Nassau.

Dr. Leon S. Eisenman of Hialeah appeared on the program of the Third Serendipity Conference on January 28 at the Bahamas Conferences in Nassau.

An organizational meeting for the Florida Association for Cleft Palate Rehabilitation was held in Tampa September 10. Spirits were dampened a little by hurricance "Donna," which also chose to be present that morning, nevertheless, the following executive council was elected: McKenzie Buck, Ph.D., Gainesville, president; Clifford C. Snyder, M.D., Miami, vice president; Neal M. Roth, D.D.S., Jacksonville, secretary; E. L. Matta, M.D., Tallahassee, treasurer, and John H. Ross, D.D.S., St. Petersburg, editor.

The next meeting will be held February 18 in the Cherry Plaza Hotel at Orlando with registration beginning at 8:15 a.m. Dr. Samuel Pruzansky, Associate Professor of Orthodontics and Associate Director of the Cleft Palate Clinic Center for Handicapped Children, University of Illinois, will be guest speaker. There will be a full day program. Those planning to attend may make reservations at the Cherry Plaza at convention rates.

Dr. Charles McC. Gray of Tampa has been elected president-elect of the Radiological Society of North America. The selection of Dr. Gray

took place at the Society's 46th annual meeting held at Cincinnati, Ohio.

Dr. Edward R. Annis of Miami represented the American Medical Association on the National Broadcasting Company television program "The Nation's Future" originating from New York City January 14. Topic for the debate by Dr. Annis and Senator Hubert Humphrey (D.Minn.) was "Should medical care for the aged be linked to social security?"

Two intensive postgraduate courses are planned for February and March at the Medical College of Georgia, Augusta. Featured faculty will include Dr. Edgar A. Hines Jr. from the Mayo Clinic and Dr. Buford Word, Professor of Gynecology at the Medical College of Alabama. "Management of Your Patient with Vascular Disease" is scheduled for February 28-March 2, and "Gynecology in General Practice" will be held March 21-23. Application may be made by contacting Dr. Claude-Starr Wright, Director, Department of Continuing Education, Medical College of Georgia, Augusta.

Drs. J. K. David Jr., Joel Fleet, Stephen P. Gyland Jr., Benjamin A. Johnson Jr. and Camillus L'Engle of Jacksonville were among the group of physicians attending the annual meeting of the Florida Pediatric Society held in Jamaica.

Dr. Kenneth A. Morris of Jacksonville was elected vice president of the Southern Surgical Association at the annual meeting in December held at Boca Raton. Dr. Morris served as chairman of the program committee for the session.

Dr. Samuel M. Day of Jacksonville, Secretary-Treasurer of the Florida Medical Association, attended the two day conference on "Education Problems in the Intern and Residency Program in the Community Hospital" sponsored in December by the Pennsylvania Graduate School of Medicine at Philadelphia.

The Fifth Annual Watson Clinic Seminar has been scheduled for March 4 in the library of the Watson Clinic Building at Lakeland. Dr. Coy L. Lay of Lakeland is program chairman. The general theme of the Seminar will be recent advances in medicine and surgery.

COMPONENT SOCIETY NOTES

Alachua

Dr. Raymond J. Fitzpatrick of Gainesville has been installed as president of the Alachua County Medical Society. Dr. William P. Hadley of Gainesville has been chosen president-elect. Serving this year with Drs. Fitzpatrick and Hadley will be Drs. Peter F. Regan as vice president, Richard E. Perry as secretary and George A. Dell as treasurer. Dr. Perry was re-elected, all are from Gainesville.

Bay

Dr. John J. Holloman Jr. has been installed as president of the Bay County Medical Society. Dr. Roderick C. Webb has been elected vice president, Dr. A. Ralph Monaco, secretary and Dr. Charles H. Daffin, treasurer. All are from Panama City.

Brevard

Dr. Willard H. Bennett of Titusville has been installed as president of the Brevard County Medical Society for the new year. Dr. Joseph C. Von Thron of Cocoa Beach who served as treasurer in 1960 has been chosen as president-elect. Other officers elected at the Society's annual meeting include Dr. Spencer C. Manrodt of Melbourne as vice president, Dr. Herbert L. Allen of Melbourne as treasurer, and Dr. Frederick H. Lucas of Cocoa Beach as secretary. Dr. Manrodt was formerly secretary.

Clay

Dr. William A. Mulford of Green Cove Springs has been elected president of the Clay County Medical Society. Chosen at the recent annual meeting to serve with Dr. Mulford were Dr. Aubrey Y. Covington of Starke as vice president and Dr. Joseph G. Ritch Jr. of Orange Park as secretary-treasurer.

Columbia

Dr. Harry S. Howell has been re-elected as president of the Columbia County Medical Society. Other officers re-elected at the Society's annual meeting in December included Dr. Louis G. Landrum as vice president and Dr. Thomas H. Bates as secretary-treasurer. All are from Lake City.

At the December meeting, Dr. Walter H. Thiele and Dr. Claude C. Burton, Head of the

(Continued on page 946)



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Twenty-Ninth Annual Assembly

MARCH 6, 7, 8, 9, 1961

(Monday, Tuesday, Wednesday, Thursday)

DEAUVILLE HOTEL • MIAMI BEACH, FLA.

Speakers

Monday, March 6

WARREN H. COLE, M.D., (Guest), Chicago, Ill., Professor and Head, Department of Surg., Univ. of Ill. College of Med.; Surgeon-in-Chief, Research and Educational Hospitals, Univ. of Ill.
Surgical Aspects of Jaundice

OWEN H. WANGENSTEEN, M.D., (Guest), Minneapolis, Minn., Professor and Chairman, Dept. of Surg., Univ. of Minn. Medical Center
Local Gastric Cooling in the Control of Massive Gastric Hemorrhage

IRA A. FERGUSON, M.D., Atlanta, Ga., Chief of Surg., Grady Memorial Hosp.; Prof. of Surg., Emory Univ. Med. School
Upper Gastrointestinal Bleeding

Discusser: DONALD S. DANIEL, M.D., Richmond, Va., Ass't Prof. of Surg., Med. College of Va.; Surgeon, Johnston-Willis Hosp.

JOHN J. FARRELL, M.D., Miami, Fla., Professor and Chairman, Department of Surg., Univ. of Miami School of Med.
Surgical Management of Massive Upper G. I. Tract Bleeding

Discusser: R. C. WIGGINTON, M.D., F.A.C.S., Corinth, Miss.

ROSS Z. PIERPONT, M.D., F.A.C.S., Baltimore, Md., Chief of Surg., Maryland General Hosp.; Assoc. in Surgical Anatomy and Instr. in Surg., Univ. of Maryland School of Med.
Vagotomy and Gastric Drainage for Peptic Ulcer

Discusser: LEONARD W. EDWARDS, M.D., Nashville, Tenn.

CECIL E. NEWELL, M.D., M.S., (in Surg.), F.A.C.S., Chattanooga, Tenn., Surg., Baroness Erlanger and Newell Hosps.
The Prognosis of Cancer of the Stomach

Discusser: FREDERICK F. BOYCE, M.D., New Orleans, La.

RICHARD B. CATTELL, M.D., (Guest), Boston, Mass., Director, Lahey Clinic; Surgeon-in-Chief, New England Baptist Hosp.; Chairman, Med. Adm. Board and Surgeon, New England Deaconess Hosp.
Management of Cancer of the Pancreas

WILLARD H. PARSONS, M.D., Vicksburg, Miss., President of the Southeastern Surgical Congress; Chief of Staff, Vicksburg Hosp.; Director of Surg., Clinical Assoc. Professor of Surg., Univ. Medical Center, Jackson, Miss.; Att. Surgeon, Vicksburg, Kuhn Memorial and University Hospitals; Regent, American College of Surgeons
PRESIDENTIAL ADDRESS—The Past, the Present, Perhaps the Future of the Southeastern Surgical Congress

ROBERT J. COFFEY, M.D., Washington, D.C., Professor of Surg. and Dir. Dept. of Surg., Georgetown Univ. School of Med.
Problems in the Diagnosis and Treatment of Chronic Pancreatitis

Discusser: WILLIAM T. WILLIAMS, M.D., Dunedin, Fla., Surgeon, Mease Clinic

PAUL JORDAN, JR., M.D., Gainesville, Fla., Assoc. Prof. of Surg., University of Fla. Med. School
Effect of Pancreatectomy Upon Biliary Composition

Discusser: WILLIAM W. SHINGLETON, M.D., Durham, N. C., Professor of Surg., Duke Univ. Medical School

BERNARD ZIMMERMANN, M.D., Morgantown, W. Va., Professor of Surg., and Chairman of Dept., Univ. of W. Va. Medical School
The Dynamics of Electrolyte Balance in the Postoperative Surgical Patient

Discusser: CHAMP LYONS, M.D., Birmingham, Ala., Professor of Surg. and Chairman of Department, Univ. of Ala. Medical College

CLINTON L. BORDER, JR., M.D., Miami, Fla., Ass't Professor of Surg., Univ. of Miami School of Med.
Cholecystitis: Early vs. Delayed Surgical Management

Discusser: HOWARD MAHORNER, M.D., New Orleans, La., Clinical Professor of Surg., La. State Univ. School of Med.; Director, Mahorner Clinic

Panel Discussion: *Diseases of the Gallbladder*

Moderator: DONALD S. DANIEL, M.D., Richmond, Va.

Discussers: RICHARD B. CATTELL, M.D., Boston, Mass.
OWEN WANGENSTEEN, M.D., Minneapolis, Minn.
WARREN COLE, M.D., Chicago, Ill.

Tuesday, March 7

OWEN H. WANGENSTEEN, M.D., (Guest), Minneapolis, Minn., Professor and Chairman, Department of Surg., Univ. of Minn. Medical Center
The Extended Operation for Alimentary Tract Cancer

PHILIP H. PHILBIN, M.D., Washington, D.C., Senior Att. Surg., Washington Hospital Center; Att. Surg., Children's Hosp. of the District of Columbia; Instr. in Surg., Georgetown Univ. School of Med.
Malignant Tumors of the Head and Neck in Children

Discusser: JESSE W. CASTLEBERRY, M.D., Orlando, Fla.

CLAUDE C. COLEMAN, JR., M.D., Charlottesville, Va., Chief, Div. of Plastic and Maxillofacial Surgery, Univ. of Va. School of Med.

WILLIAM P. SADLER, JR., M.D., Charlottesville, Va., Resident Surgeon, Univ. of Va. Hosp.
Recurrent Cancer of the Head and Neck

Discusser: JOHN F. POTTER, M.D., Washington, D.C., Coordinator, Oncology Service, Georgetown Univ. Hosp.

THOMAS FLORENCE, M.D., Atlanta, Ga.
WILLIAM CHAMBLESS, M.D., Atlanta, Ga.
Fertility Studies in the Male

Discusser: MAJOR F. FOWLER, M.D., Atlanta, Ga.

W. VINSON PIERCE, M.D., F.A.C.S., Covington, Ky.
Diagnosis and Management of Primary Tumors of the Ureter

Discusser: RUSSELL B. CARSON, M.D., Fort Lauderdale, Fla.

RICHARD B. CATTELL, M.D., (Guest), Boston, Mass., Director, Lahey Clinic; Surgeon-in-Chief, New England Baptist Hospital; Chairman, Med. Adm. Board and Surgeon, New England Deaconess Hospital
Benign Strictures of Bile Ducts

Watts R. Webb, M.D., Jackson, Miss., Assoc. Professor of Surg., Univ. Medical Center
Current Concepts of the Management of Mediastinitis

Discusser: John B. Blalock, M.D., New Orleans, La., Instr. in Surg., Tulane Univ. School of Med.; Member of Staff, Ochsner Clinic

Theodore L. Batchelder, M.D., Jacksonville, Fla., Chairman of Cardiac Surg. Section, Duval Med. Center
Critical Factors in Determining Adequate Pleural Drainage in Both the Operated and Non-Operated Chest

Discusser: Wendell B. Thrower, M.D., Charleston S. C., Ass't Professor of Surg., Thoracic and Cardiovascular, Med. College of S. C.

FORUM ON PROGRESS IN SURGERY

Effect of Alcohol and Histamine on Pancreatic Secretion
E. R. Woodward, M.D., B. E. Walton, M.D., H. Schapiro, M.D., Gainesville, Fla.

Results of Fibrinolysin Therapy on Experimentally Induced Pancreatitis
Paul U. Gerber, Jr., M.D., William H. Meyer, Jr., M.D., John J. Farrell, M.D., Coral Gables, Fla.

Post-Operative Management of Patients with Billroth I Gastrectomy and Vagotomy
Gilbert A. Rannick, M.D., Carroll H. Long, M.D., Johnson City, Tenn.

Fluid Shifts in Peritonitis
George R. Walker, Jr., M.D., James D. Hardy, M.D., Jackson, Miss.

Low Molecular Weight Dextran as a Protective Agent Against the Toxic Effects of Urokon
Robert T. Sessions, M.D., Duncan A. Killen, M.D., John H. Foster, M.D., Nashville, Tenn.

Thiosulfate Protection Against the Toxic Effects of Nitrogen Mustard in Perfusion of the Liver
John H. Foster, M.D., Malcolm R. Lewis, M.D., J. Kenneth Jacobs, M.D., Nashville, Tenn.

Volumetric Arm Measurements—Technique and Results
Harold S. Engler, M.D., Russell D. Sweat, Augusta, Ga.

Composite (Teflon and Autogenous Vein) Grafts in small Canine Arteries
William R. Pridgen, M.D., W. Andrew Dale, M.D., Nashville, Tenn.

Coronary Arteriovenous Fistula Simulating Patent Ductus Arteriosus
Daniel B. Nunn, M.D., Wendell B. Thrower, M.D., Charleston, S. C.

Analysis of 400 Consecutive Stab Wounds of the Abdomen
L. K. Moss, M.D., Oscar Creech, Jr., M.D., New Orleans, La.

Wednesday, March 8

John M. Waugh, M.D., (Guest), Professor of Surgery, Mayo Foundation, Rochester, Minn.
The Choice of Operation and Management of Carcinoma of the Rectum

John L. Carmichael, M.D., Birmingham, Ala., Clinical Professor of Surg., Medical College of Ala.
Surgical Treatment of Ulcerative Colitis

Discusser: William H. Moretz, M.D., Augusta, Ga. Professor and Chairman of Department of Surg., Medical College of Ga.

Keith S. Grimson, M.D., Durham, N. C., Professor of Surg., Duke University Med. Center
Subtotal Colectomy for Intractable Constipation or Diarrhea

Discusser: Hu C. Myers, M.D., Philippi, W. Va., Chief of Surg., Broaddus Hosp. and Myers Clinic

Warren H. Cole, M.D., (Guest), Chicago, Ill., Professor and Head, Department of Surg., Univ. of Ill. College of Med.; Surgeon-in-Chief, Research and Educational Hospitals, Univ. of Ill.
Intestinal Obstruction

Henry B. Asman, M.D., F.A.C.S., Louisville, Ky., Chief, Proctology Service, Department of Surg., St. Joseph Infirmary
Radical Hemorrhoidectomy

Discusser. William H. Prioleau, M.D., Charleston, S. C., Director of Surg., Roper Hospital; Clinical Professor of Surg., Medical College of S. C.; Dip. Nat. Board of Medical Examiners

Marshall L. Michel, M.D., New Orleans, La., Clinical Assoc. Professor of Surg., Tulane Univ. Medical School; Senior Surg., Touro Infirmary; Senior Visiting Surg., Charity Hospital

James H. Stewart, M.D., New Orleans, La., Instr. in Surg., Tulane Univ. Medical School
Meckel's Diverticulum

Discusser: Elton S. Thomas, M.D., F.A.C.S., Columbus, Miss., Surgeon, Columbus Hospital

Harris B. Shumaker, Jr., M.D., (Guest), Indianapolis, Ind., Professor of Surg. and Chairman of the Department of Surg., Indiana Univ. Medical Center
Management of Peripheral Arterial Embolism

George H. Yeager, M.D., F.A.C.S., Baltimore, Md., Professor of Clinical Surg., Univ. of Md. School of Med.

Wilfred F. Holdefer, Jr., M.D., Baltimore, Md., Pangborn Fellow in Surg., Univ. of Md. School of Med.
Peripheral Vascular Disease—Surgical Considerations

Discusser: Thomas B. Patton, M.D., Birmingham, Ala., Assoc. Professor of Surg., Medical College of Ala.

Benjamin F. Byrd, Jr., M.D., Nashville, Tenn., Assoc. Clinical Professor of Surg., Vanderbilt Univ. School of Med., Att. Surgeon, University, St. Thomas and Baptist Hosps.
Inflammatory or Inflamed Carcinoma of the Breast

Discusser: Francis M. Massie, M.D., Lexington, Ky., Senior Surgeon, Lexington Clinic, Surg. Staff, St. Joseph Hospital

Howard Patterson, M.D., (Guest), New York, N. Y., Chief of Surg., Roosevelt Hospital; Clinical Professor of Surg., Columbia Univ.
The Clinical Behavior of Carcinoma of the Cecum

Claude G. Callender, M.D., Jackson, Miss., Clinical Ass't Professor, Univ. of Miss. Medical School, Department of Ob. and Gyn.
Complication of Vaginal Hysterectomy

Discusser: Battle Malone, II, M.D., Memphis, Tenn.

Nicholas W. Fugo, M.D., Morgantown, W. Va., Professor of Obstetrics and Gynecology, Univ. of W. Va. Medical School
The Clinical Application of the Oxytocic Sensitivity Test

Discusser: James H. Ferguson, M.D., Miami, Fla., Professor and Chairman, Department of Ob. Gyn., Univ. of Miami Medical School

CHARLES W. SMITH, M.D., Atlanta, Ga.
The Clinical Significance of Class III Cervical Pap Smear

Discusser: T. KERR LAIRD, M.D., Montgomery, W. Va., Surgeon, Laird Mem. Hosp.

Winner of First Place, Scientific Paper Award Contest
Name and Title to be announced

Panel Discussion: *Diverticulitis*

Moderator: HARVEY B. STONE, M.D., Baltimore, Md., Associate Professor of Surg. (Emeritus), The Johns Hopkins Medical School

Discussers: HOWARD PATTERSON, M.D., New York, N. Y.
JOHN M. WAUGH, M.D., Rochester, N. Y.,
J. D. MARTIN, JR., M.D., Atlanta, Ga., Professor and Chairman, Department of Surg., Emory Univ. Medical School

Thursday, March 9

HARRIS B. SHUMACKER, JR., M.D., (Guest), Indianapolis, Ind., Professor of Surg. and Chairman of the Department of Surg., Indiana Univ. Medical Center
Pulmonary Valvulotomy—With Extracorporeal Circulation or Not?

HOWARD PATTERSON, M.D., (Guest), New York, N. Y., Chief of Surg., Roosevelt Hosp.; Clinical Professor of Surg., Columbia Univ.
Unusual Surgical Lesions of the Stomach

JAMES D. RIVES, M.D., New Orleans, La., Professor and Head, Department of Surg., La. State Univ. School of Med.; Surgeon-in-Chief, L. S. U. Surg. Service, Charity Hosp. of La.
The Treatment of Congenital Diaphragmatic Hernias

Discusser: FRANK S. ASHBURN, M.D., Washington, D. C., Chief, Thoracic Surg., Doctors Hosp.; Assoc. in Thoracic Surg., Georgetown Univ.

FRANK F. ESPEY, M.D., Greenville, S. C., Senior Consultant in Neurosurgery, Greenville General Hosp.
Treatment of Intractable Pain by Cordotomy

Discusser: M. FRANK TURNEY, M.D., Knoxville, Tenn., Head, Department of Neurosurgery, Univ. of Tenn. Memorial & Research Hosp.

WALKER REYNOLDS, JR., M.D., M.S., (Surg.), F.A.C.S., Anniston, Ala. Chief of Surg., Anniston Memorial Hosp.; Instr. in Surg., Medical College of Ala.
Practical Aspects of Burn Therapy

Discusser: CURTIS ARTZ, M.D., Jackson, Miss., Assoc. Professor of Surg., Univ. of Miss. Medical Center

JOSEPH P. CAIN, JR., M.D., Mullins, S. C.
The Intramedullary Pin as an Aid to the General Surgeon in the Treatment of Complicated Fractures of the Long Bones

Discusser: WILLIAM BONDURANT, M.D., F.A.C.S., Atlanta, Ga., Assoc. in Surg., Orthopedics, Emory University Medical School.

AMOS R. KOONTZ, M.D., Baltimore, Md., Ass't Professor of Surg. (Emeritus), The Johns Hopkins Medical School
Sutures and Prostheses for Abdominal Wall Defects

Discusser: STUART G. BLACKSHEAR, M.D., F.A.C.S., Gainesville, Ga.

JOHN M. WAUGH, M.D., (Guest), Professor of Surg., Mayo Foundation, Rochester, Minn.
Operations for Chronic Pancreatitis

INFORMATION

Speakers are listed as nearly as possible as they will appear in the completed program. For hotel reservations, write to the manager of the Deauville Hotel, Miami Beach, Fla. For further information write to

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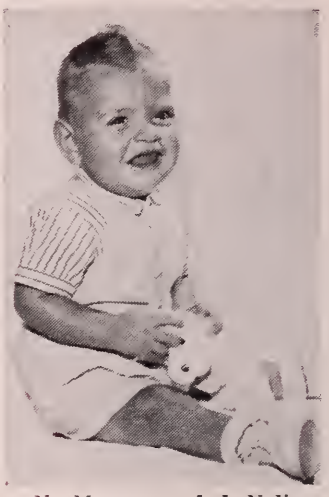
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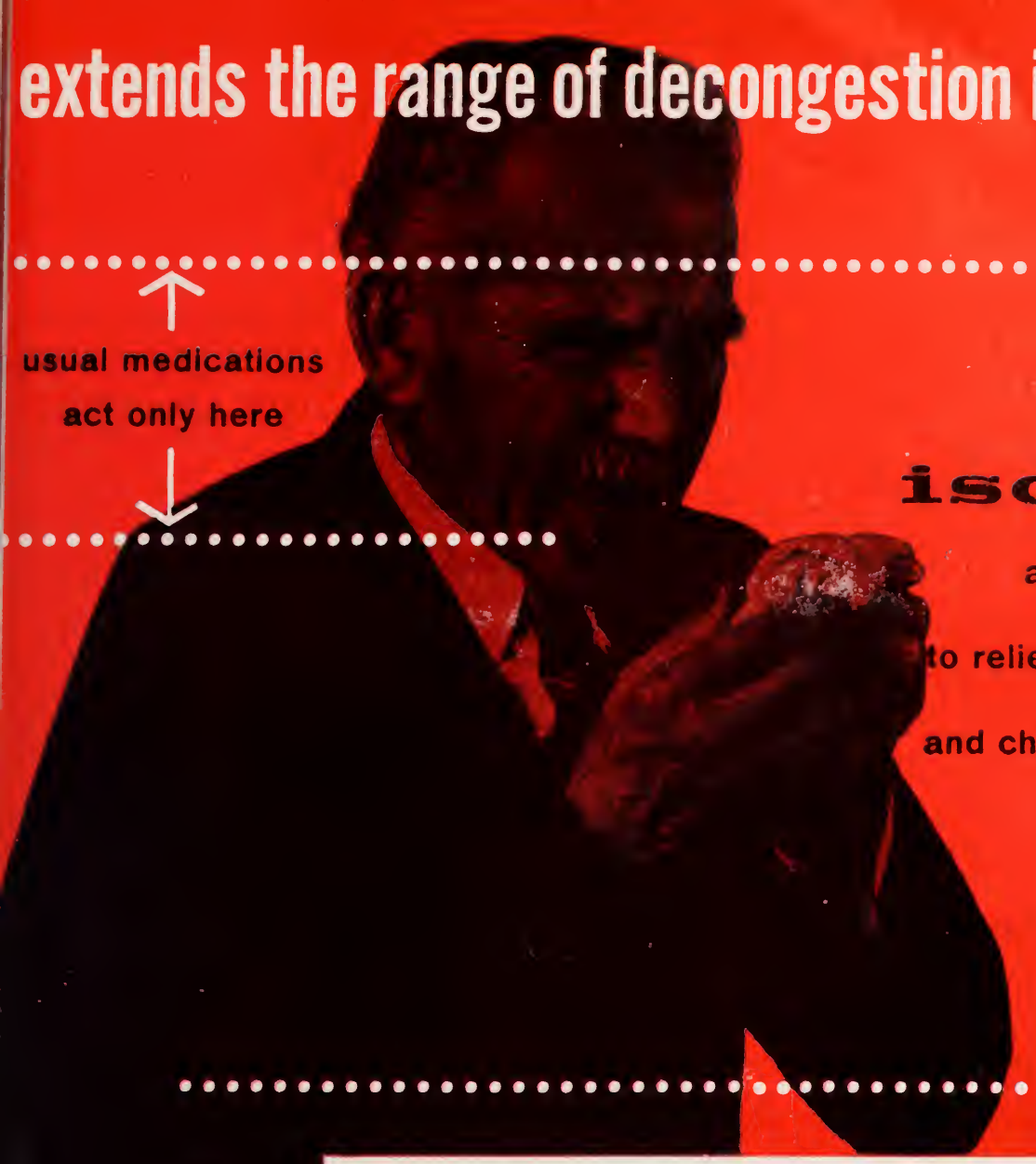
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1. Aviado, D. M. et al: J. Pharmacol. & Exper. Therap. 122: 406-417 (Mar.) 1958. 2. Laboratory Report: Research Div., Chas. C. Haskell & Co., 1959.

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References: 1. Curran, T. R., and Phelps, D. K.: Am. Pract. & Dig. Treat. *11:* 617, 1960. 2. Levy, S.: J.A.M.A. *153:* 1260, 1953. 3. Connolly, R.: W. Va. Med. J. *56:* 263, 1960.



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(Continued from page 932)

Department of Surgery at the Veterans Administration Hospital, Lake City, were guests. Dr. Burton delivered an address on hernia.

Dade

Dr. Willard L. Fitzgerald has been installed as president of the Dade County Medical Association, and Dr. James L. Anderson has been elected president-elect. Dr. Francis N. Cooke has been chosen as vice president, Dr. George W. Robertson III as secretary, and Dr. Paul S. Jarrett as been re-elected treasurer. All are from Miami.

DeSoto-Hardee-Glades

Dr. Albert S. Lasky of Sarasota was featured speaker at the December meeting of the DeSoto-Hardee-Glades County Medical Society held at Arcadia. His subject was maxillofacial and reconstructive surgery.

Duval

Dr. Sidney Stillman has been installed as president of the Duval County Medical Society. Dr. Thomas M. Irwin has been chosen president-elect, Dr. Archibald F. Caraway Jr. vice president, Dr. Robert J. Brown secretary and Dr. Lee S. Bransford Jr. treasurer. Dr. Brown served the Society as treasurer last year. All are from Jacksonville.

Escambia

Dr. P. G. Batson Jr. has begun serving as president of the Escambia County Medical Society following installation ceremonies at the Society's annual meeting. Dr. Joseph L. Rubel, president-elect, Dr. William T. Patton, vice president, and Dr. Vernon L. Smith, secretary-treasurer, are the other new officers who will be serving during 1961. All are from Pensacola.

Franklin-Gulf

Dr. William F. Wager of Port St. Joe has been elected president of the Franklin-Gulf County Medical Society. Chosen to serve with Dr. Wager were Dr. Harold B. Canning of Wewahitchka a vice president, and Dr. Henry I. Langston of Apalachicola as secretary-treasurer.

Highlands

Dr. Samuel A. King of Avon Park has been elected president of the Highlands County Medical Society. Dr. C. Brooks Henderson of Avon Park has been chosen as secretary-treasurer, and

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Dr. Carl J. Larsen of Avon Park has been re-elected vice president.

Hillsborough

Dr. Herbert B. Lott has assumed the duties as president of the Hillsborough County Medical Association after serving as president-elect last year. Chosen as president-elect at the Association's recent annual meeting was Dr. Samuel G. Hibbs. Serving with Drs. Lott and Hibbs will be Dr. Richard G. Connar as first vice president, Dr. Victor H. Knight Jr. as second vice president, Dr. Frank A. Massari as secretary and Dr. Marvin B. Miller as treasurer. Drs. Massari and Miller were re-elected. All are from Tampa.

Indian River

Dr. Phil D. Morgan has been elected president of the Indian River County Medical Society after serving last year as vice president. Dr. Hampton L. Schofield Jr. has been chosen as vice president, and Dr. Walter W. McCorkle has been re-elected secretary-treasurer. All are from Vero Beach.

Lake

Dr. Lawton F. Douglass of Umatilla has been installed as president of the Lake County Medical Society, and Dr. Thomas D. Weaver of Clermont, who has been serving as secretary-treasurer, was chosen president-elect at the Society's recent annual meeting. The new secretary-treasurer is Dr. Raymond A. Debo of Eustis.

Leon-Gadsden-Liberty-Wakulla-Jefferson

Dr. Nelson H. Kraeft of Tallahassee has been elected president of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society. Serving with Dr. Kraeft will be Dr. H. Lawrence Smith of Tallahassee as vice president, and Dr. David J. McCulloch of Tallahassee as secretary-treasurer. Dr. McCulloch was re-elected.

Madison

Dr. Julian M. DuRant has been elected president of the Madison County Medical Society, and Dr. A. Franklin Harrison has been chosen secretary-treasurer. Both are from Madison.

Monroe

Dr. Chas. J. McPeak, Staff Surgeon at the Sloan-Kettering Memorial Hospital for Cancer and Allied Diseases, addressed a recent joint meeting of the Monroe County Medical Society and the staff of the U. S. Naval Hospital at Key

(Continued on page 951)

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tamin A	(5000 units) 1.5 mg.
tamin D	(1000 units) 25 mcg.
iamine Mononitrate (B_1)	2 mg.
boflavin (B_2)	2 mg.
cotinamide	20 mg.
ridoxine Hydrochloride	0.5 mg.
balamin (Vitamin B_{12})	2 mcg.
lcium Pantothenate	5 mg.
scorbic Acid (C)	50 mg.
n (as sulfate)	10 mg.
pper (as sulfate)	0.15 mg.
dine (as calcium iodate)	0.1 mg.
anganese (as sulfate)	0.05 mg.
agnesium (as oxide)	0.15 mg.
lcium (as phosphate)	250 mg.
osphorus (as calcium phosphate)	193 mg.

n table bottles of 100, bottles of 250 & 1000

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ch Filmtab® represents:

tamin A	3 mg. (10,000 units)
tamin D	25 mcg. (1000 units)
iamine Mononitrate	5 mg.
boflavin	5 mg.
cotinamide	25 mg.
ridoxine Hydrochloride	2 mg.
balamin (Vitamin B_{12})	2 mcg.
lcium Pantothenate	5 mg.
scorbic Acid	100 mg.

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AYALETS-M® Each Filmtab represents all the tamins of Dayalets plus the following:

n (as sulfate)	10 mg.
pper (as sulfate)	1 mg.
dine (as calcium iodate)	0.15 mg.
balt (as sulfate)	0.1 mg.
anganese (as sulfate)	1 mg.
agnesium (as oxide)	5 mg.
nc (as sulfate)	1.5 mg.
olybdenum (as sodium molybdate)	0.2 mg.

n table bottles of 100 & 250, bottles of 1000

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OPTILETS® Therapeutic formulas for more severe deficiencies—illness, infection, etc.

Each Filmtab® represents:

Vitamin A	7.5 mg.(25,000 units)
Vitamin D	25 mcg. (1000 units)
Thiamine Hydrochloride	10 mg.
Riboflavin	5 mg.
Nicotinamide	100 mg.
Pyridoxine Hydrochloride	5 mg.
Cobalamin (Vitamin B_{12})	6 mcg.
Calcium Pantothenate	20 mg.
Ascorbic Acid	200 mg.

In table bottles of 30 & 100, bottles of 1000

OPTILETS-M® Each Filmtab represents all the vitamins of Optilets plus the following:

Iron (as sulfate)	10 mg.
Copper (as sulfate)	1 mg.
Iodine (as calcium iodate)	0.15 mg.
Cobalt (as sulfate)	0.1 mg.
Manganese (as sulfate)	1 mg.
Magnesium (as oxide)	5 mg.
Zinc (as sulfate)	1.5 mg.
Molybdenum (as sodium molybdate)	0.2 mg.

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SUR-BEX® WITH C Therapeutic B-complex with C, for convalescence, stress, post-surgery.

Each Filmtab® represents:

Thiamine Mononitrate	6 mg.
Riboflavin	6 mg.
Nicotinamide	30 mg.
Pyridoxine Hydrochloride	2.5 mg.
Cobalamin (Vitamin B_{12})	2 mcg.
Calcium Pantothenate	10 mg.
Ascorbic Acid	150 mg.
Desiccated Liver, N.F.	150 mg.
Liver Fraction 2, N.F.	150 mg.
Brewer's Yeast Dried	150 mg.

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(Continued from page 949)

West. Dr. McPeak's subject was "Surgery of Cancer of the Head and Neck." He described a method of treatment of advanced cases of cancer of the head and neck with infusion of chemotherapeutic agents carried on over a period of a week. The technical aspects and some illustrations of the results of this treatment were outlined.

Nassau

Dr. Henry B. Dickens Jr. is the new president of the Nassau County Medical Society. Serving with Dr. Dickens this year as secretary will be Dr. John B. Britton. Both are from Fernandina Beach.

Orange

Dr. Norman F. Coulter has been installed as president of the Orange County Medical Society. Chosen as president-elect at the Society's recent annual meeting was Dr. Robert W. Curry, formerly secretary. Dr. Lewis L. Kline has been elected vice president, Dr. Truett H. Frazier as secretary and Dr. Joseph G. Matthews as treasurer. All are from Orlando. Dr. Frederick E. Medlock Jr. has been chosen as reporter, and Dr. Miles W. Thomley has been re-elected editor of The Bulletin. Drs. Medlock and Thomley are also from Orlando.

Suwannee-Hamilton-Lafayette

Dr. Hugo F. Sotolongo of Live Oak has been elected president of the Suwannee-Hamilton-Lafayette County Medical Society. Serving with Dr. Sotolongo will be Dr. James F. Dietrich of Live Oak as vice president, and Dr. William P. Blackmon of Jasper as secretary-treasurer.

Taylor

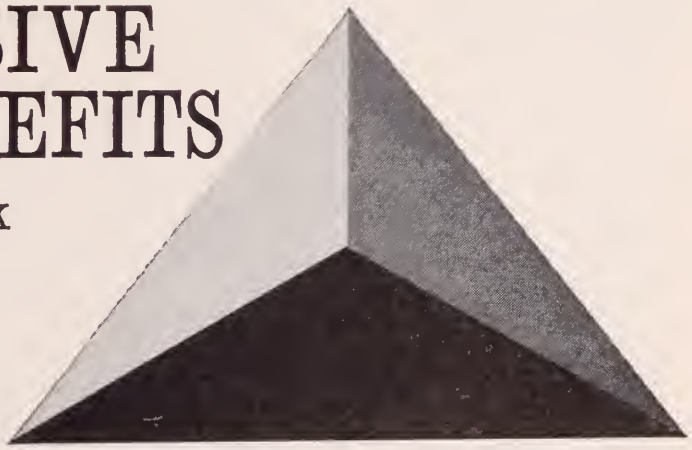
Dr. John A. Dyal Jr. of Perry has been elected president of the Taylor County Medical Society. He was formerly secretary. Dr. Charles M. Roberts also of Perry succeeds Dr. Dyal as secretary.

Volusia

Dr. C. Robert DeArmas of Daytona Beach has been installed as president of the Volusia County Medical Society. Chosen president-elect at the Society's recent annual meeting was Dr. John J. Cheleden of Daytona Beach, who was formerly secretary. Dr. Thomas W. Ayres of Daytona Beach has been elected secretary, and Dr. Robert L. Stevenson of Holly Hill treasurer.

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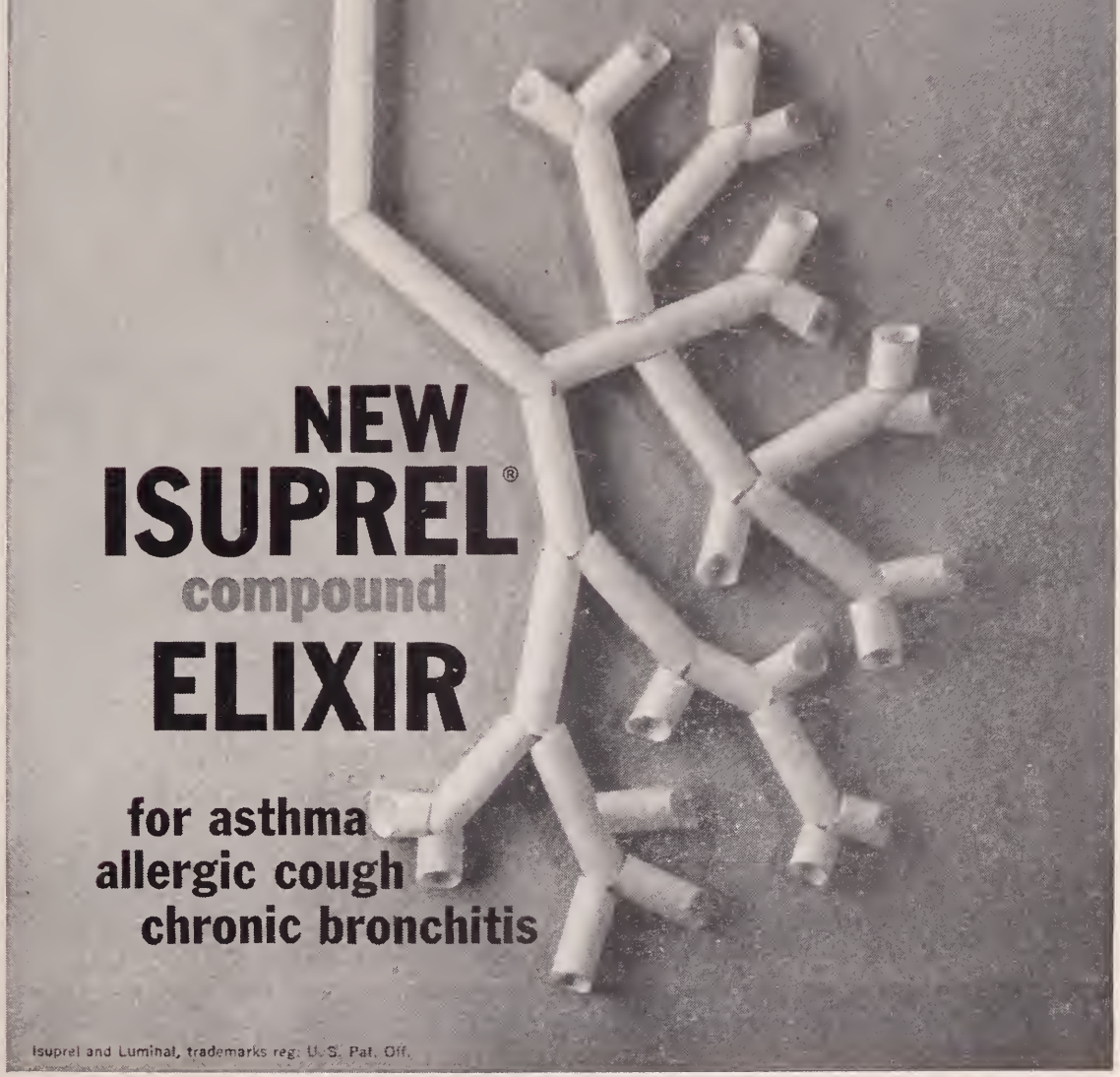
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Each tablespoon (15 cc.) contains:

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Ephedrine sulfate	12 mg.
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Potassium iodide	150 mg.
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Alcohol	19%

Dosage:
Children—from 1 to 3 teaspoons (5 to 15 cc.) three times daily as required. Adults—1 or 2 tablespoons (15 to 30 cc.) three or four times daily as required.

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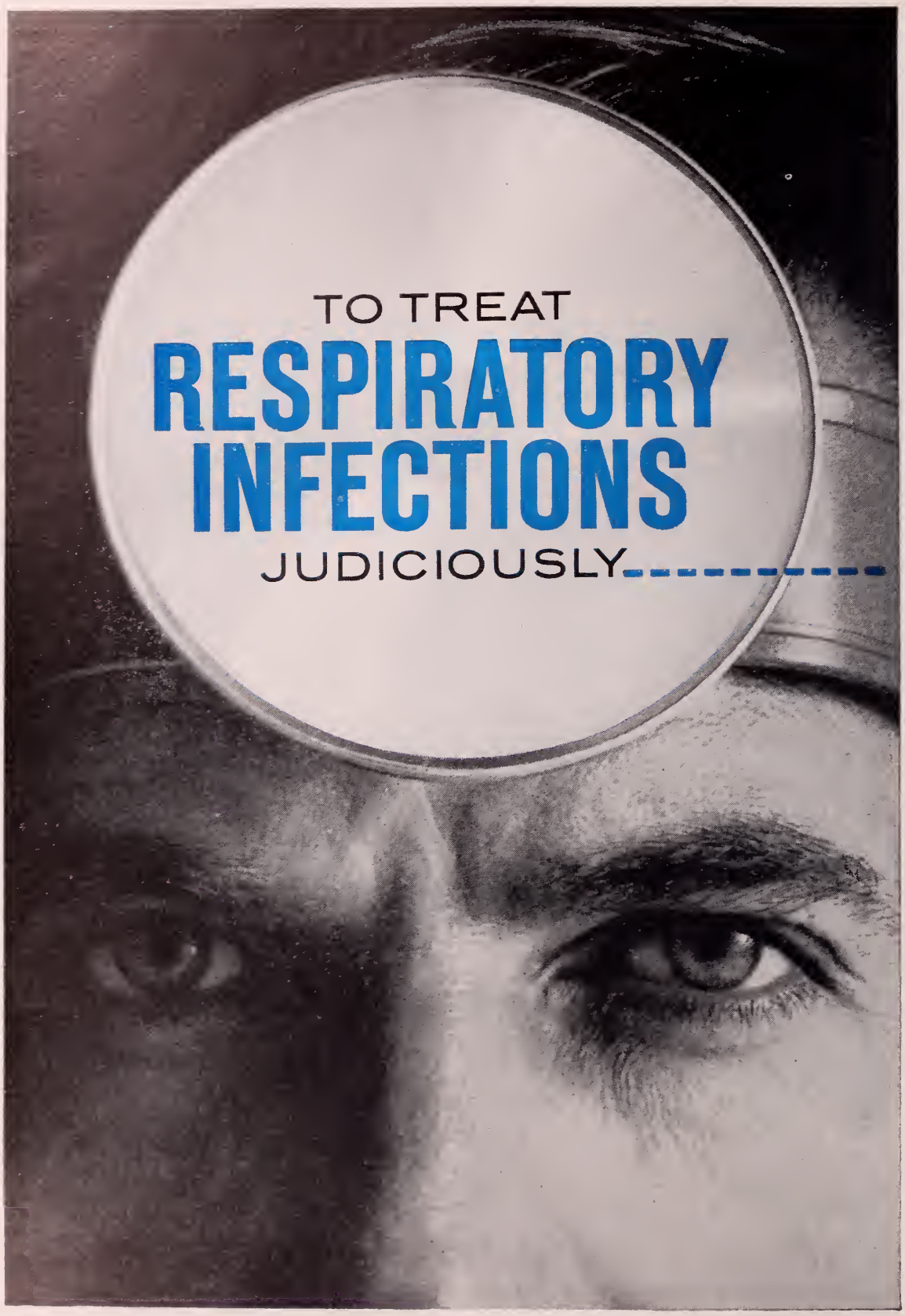


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THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

JAMA

VOL. 174, NO. 5 OCTOBER 1, 1960

newest J.A.M.A. paper[1] reports

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a relatively low incidence of gastrointestinal reactions ... were found in this series.

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stable adult diabetes • sulfonylurea failures
unstable (brittle) diabetes

1. Barclay, P. L.: J.A.M.A. 174:474, Oct. 1, 1960.

NOTE — before prescribing DBI the physician should be thoroughly familiar with general directions for its use, indications, dosage, possible side effects, precautions and contraindications, etc. Write for complete detailed literature.



To anticipate the harvest you must consider the seed from which the plant is grown.

QUALITY...

It is human nature to ask: "What's behind it?" The fact that our nation's doctors stand behind Blue Shield, through their local medical societies, is certainly an important reason for its widespread acceptance. One doctor summed it up this way: "The public will have faith in Blue Shield so long, and only so long, as we the doctors have faith in it and continue to endorse it." **BLUE SHIELD**®

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Please send me samples of available Blue Shield literature which I may distribute to my patients. ☐
Please have a Blue Shield physician relations man visit me in my office ☐ yes; ☐ no.

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ANNOUNCING—

SPECIFICALLY FOR
INFECTIONS DUE TO
"RESISTANT" STAPHYLOCOCCI

AN ENTIRELY NEW SYNTHETIC
"STAPH-CIDAL" PENICILLIN

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

UNIQUE—BECAUSE IT
RETAINS ANTIBACTERIAL
ACTIVITY IN THE PRESENCE OF
STAPHYLOCOCCAL PENICILLINASES
WHICH INACTIVATE
OTHER PENICILLINS

Bristol™

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NEW SYNTHETIC PENICILLIN FOR "RESISTANT" STAPH

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OFFICIAL PACKAGE CIRCULAR
November, 1960

STAPHCILLIN™

(sodium dimethoxyphenyl penicillin)

For Injection

DESCRIPTION

STAPHCILLIN is a unique new synthetic parenteral penicillin produced by Bristol Laboratories for the specific treatment of staphylococcal infections due to resistant organisms. Its uniqueness resides in its property of resisting inactivation by staphylococcal penicillinase. It is active against strains of staphylococci which are resistant to other penicillins.

Each dry filled vial contains: 1 Gm. STAPHCILLIN (sodium dimethoxyphenyl penicillin), equivalent to 900 mg. dimethoxyphenyl penicillin activity.

INDICATIONS

STAPHCILLIN is recommended as specific therapy only in infections due to strains of staphylococci resistant to other penicillins, e.g.:

Skin and soft tissue infections: cellulitis, wound infections, carbuncles, pyoderma, furunculosis, lymphangitis and lymphadenitis.

Respiratory infections: staphylococcal lobar or bronchopneumonia, and lung abscesses combined with indicated surgical treatment.

Other infections: staphylococcal septicemia, bacteremia, acute or subacute endocarditis, acute osteomyelitis and enterocolitis.

Infections due to penicillin-sensitive staphylococci, streptococci, pneumococci and gonococci should be treated with Syncillin™ or parenteral penicillin G rather than STAPHCILLIN. Treponemal infections should be treated with parenteral penicillin G.

DOSAGE AND ADMINISTRATION

STAPHCILLIN is well tolerated when given by deep intragluteal or intravenous injection.

As is the case with other antibiotics, the duration of therapy should be determined by the clinical and bacteriological response of the patient. Therapy should be continued for at least 48 hours after the patient has become afebrile, asymptomatic and cultures are negative. The usual duration has been 5-7 days.

Intramuscular route: The usual adult dose is 1 Gm. every 4 or 6 hours. Infants' and children's dosage is 25 mg. per Kg. (approximately 12 mg. per pound) every 6 hours.

Intravenous route: 1 Gm. every 6 hours using 50 ml. of sterile saline solution at the rate of 10 ml. per minute.

**Warning:* Solutions of STAPHCILLIN and kanamycin should not be mixed, as they rapidly inactivate each other. Data on the results of mixing STAPHCILLIN with other antibiotics are being accumulated.

DIRECTIONS FOR RECONSTITUTION

Add 1.5 ml. sterile distilled water or normal saline to a 1 Gm. vial and shake vigorously. Withdraw the clear, reconstituted solution (2.0 ml.) into a syringe and inject. The reconstituted solution contains 500 mg. of STAPHCILLIN per ml. Reconstituted solutions are stable for 24 hours under refrigeration.

For intravenous use, dilute the reconstituted dose in 50 ml. of sterile saline and inject at the rate of 10 ml. per minute.

*This statement supersedes that in the Official Package Circulars dated September and to October, 1960

(continued)

MICROBIOLOGICAL AND PHARMACOLOGICAL PROPERTIES

In vitro studies show that STAPHCILLIN is a bactericidal penicillin with activity against staphylococci resistant to penicillin G. Strains of staphylococci so far tested have been sensitive to STAPHCILLIN *in vitro* at concentrations of 1-6 mcg. per ml. These levels are readily attained in the blood and tissues by administration of STAPHCILLIN at the recommended dosage. This unique attribute is probably due to the fact that STAPHCILLIN is stable in the presence of staphylococcal penicillinase. STAPHCILLIN also resists degradation by *B. cereus* penicillinase. The antimicrobial spectrum of STAPHCILLIN with regard to other microorganisms is qualitatively similar to that of penicillin G; but considerably higher concentrations of STAPHCILLIN are required for bactericidal activity than is the case with penicillin G.

STAPHCILLIN is rapidly absorbed after intramuscular injection. Peak blood levels (6-10 mcg. ml. on the average after a 1.0 Gm. dose) are attained within 1 hour; and then progressively decline to less than 1 mcg. over a 4 to 6 hour period. It is poorly absorbed from the gastrointestinal tract. STAPHCILLIN is rapidly excreted by the kidney.

As shown by animal studies, STAPHCILLIN is readily distributed in body tissues after intramuscular injection. Of the tissues studied, highest concentrations are reached in the kidney, liver, heart and lung in that order; the spleen and muscles show lower concentrations of the antibiotic. STAPHCILLIN diffuses into human pleural and prostatic fluids, but its diffusion into the spinal fluid has not yet been completely studied. However, one patient with meningitis showed a significant concentration in his spinal fluid while on STAPHCILLIN therapy.

Toxicity studies with STAPHCILLIN and penicillin G in animals show that they have approximately the same low order of toxicity.

Certain staphylococci can be made resistant to STAPHCILLIN in the laboratory, but this resistance is not related to their penicillinase production. During the clinical trials, no STAPHCILLIN-resistant strains of staphylococci were observed or developed; the possibility of the emergence of such strains in the clinical setting awaits further observation.

PRECAUTIONS

During the clinical trials, several mild skin reactions, e.g., itching, papular eruption and erythema were observed both during and after discontinuance of STAPHCILLIN therapy. Patients with histories of hay fever, asthma, urticaria and previous sensitivity to penicillin are more likely to react adversely to the penicillins. It is important that the possibility of penicillin anaphylaxis be kept in mind. Epinephrine and the usual adjuvants (antihistamines, corticosteroids) should be available for emergency treatment. Because of the resistance of STAPHCILLIN to destruction by penicillinase, parenteral *B. cereus* penicillinase may not be effective for the treatment of allergic reactions. Information with regard to cross-allergenicity between penicillin G, penicillin V, phenethicillin (Syncillin) and STAPHCILLIN is not available at present. If superinfection due to Gram-negative organisms or fungi occurs during STAPHCILLIN therapy, appropriate measures should be taken.

SUPPLY

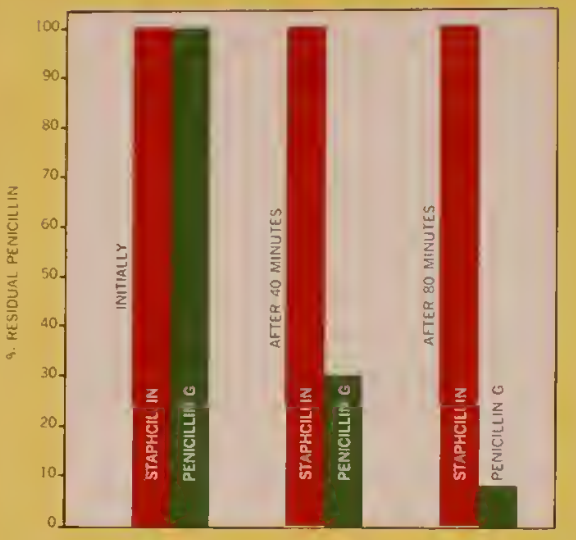
List 79502 — 1.0 Gm. dry filled vial.

BRISTOL LABORATORIES · SYRACUSE, NEW YORK
Division of Bristol-Myers Company

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UNIQUE SYNTHETIC "STAPH-CIDAL" PENICILLIN

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In the presence of staphylococcal penicillinase, STAPHCILLIN remained active and retained its antibacterial action. By contrast, penicillin G was rapidly destroyed in the same period of time. *(After Gourevitch et al., to be published)*

Specifically for "resistant" staph...

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

The failure of staphylococcal infections to respond to penicillin therapy is attributed to the penicillin-destroying enzyme, penicillinase, produced by the invading staphylococcus.

Unlike other penicillins:

1 STAPHCILLIN is effective because it retains its antibacterial activity despite the presence of staphylococcal penicillinase.

2 The clinical effectiveness of STAPHCILLIN has been confirmed by dramatic results in a wide variety of infections due to "resistant" staphylococci, many of which were serious and life-threatening.

Like other penicillins:

STAPHCILLIN has no significant systemic toxicity. It is well tolerated locally, and pain or irritation at the injection site is comparable to that following the injection of penicillin G. *In occasional cases, typical penicillin reactions may be experienced.*

PROFESSIONAL INFORMATION SERVICE — The attached Official Package Circular provides complete information on the indications, dosage, and precautions for the use of STAPHCILLIN. If you desire additional information concerning clinical experiences with STAPHCILLIN, the Medical Department of Bristol Laboratories is at your service. You may direct your inquiries via collect telephone call to New York, PLaza 7-7061, or by mail to Medical Department, Bristol Laboratories, 630 Fifth Ave., N. Y. 20, N. Y.

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with proficient defense
that cuts the cost

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CHELATION — (GR-CHELE: CLAW OR TO HOLD.)

The FIRST Hematinic to Contain BOTH CHELATED IRON and CHELATED MINERALS Assuring a Truly Flavorful, Better Tolerated Iron Therapy.

ADVANTAGES —
Chelated Iron PLUS 4 Chelated Minerals • High Therapeutic Effectiveness • Less Irritation — even on empty stomach • No Tooth Stain • Less Toxic • B-Vitamins for Added Hemopoietic Activity • Pleasant Flavor • Economical

KELATRATE
LIQUID HEMATINIC
CHELATED IRON-MINERALS and VITAMINS

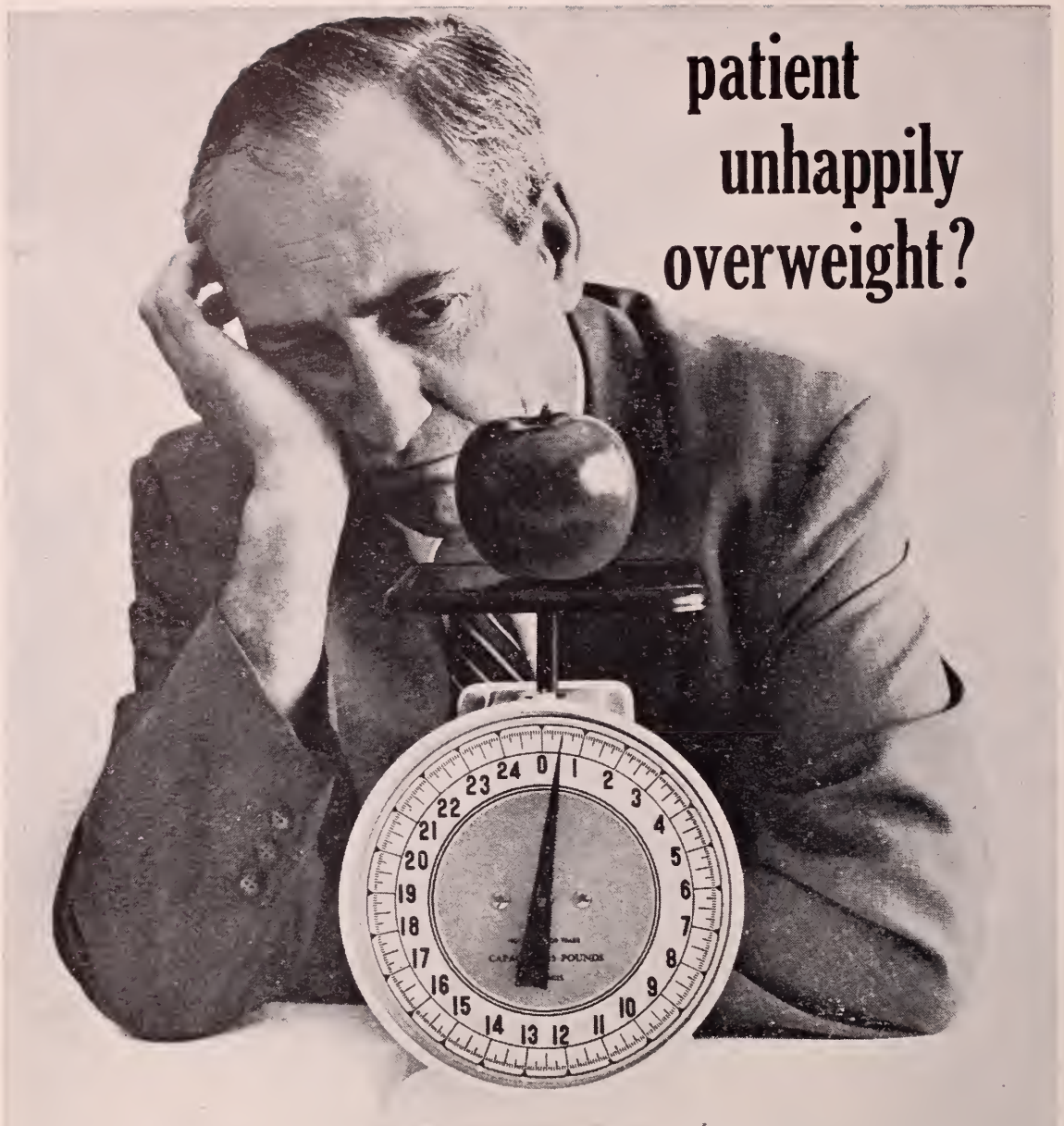
FORMULA —
Each 5 cc. (one teaspoonful) contains:

Iron (as Ferrous Betaine Citrate)	30 mg.
Cobalt (as Cobaltous Betaine Citrate)	0.1 mg.
Manganese (as Manganese Betaine Citrate)	1.0 mg.
Zinc (as Zinc Betaine Citrate)	1.25 mg.
Magnesium (as Magnesium Betaine Citrate)	6.0 mg.
Vitamin B-1	1.5 mg.
Vitamin B-2	1.2 mg.
Vitamin B-12	6.0 mcg.
Niacinamide	10 mg.
Panthenol	10 mg.

In an exceptionally pleasant tasting base.

Comprehensive literature and samples on request.

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TUTAG



minimize care and eliminate despair with

'METHEDRINE'®

brand Methamphetamine Hydrochloride

Controls food craving, keeps the reducer happy—In obesity, "our drug of choice has been methedrine . . . because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent."[1] Literature available on request.

Supplied: Tablets 5 mg., scored. Bottles of 100 and 1000.

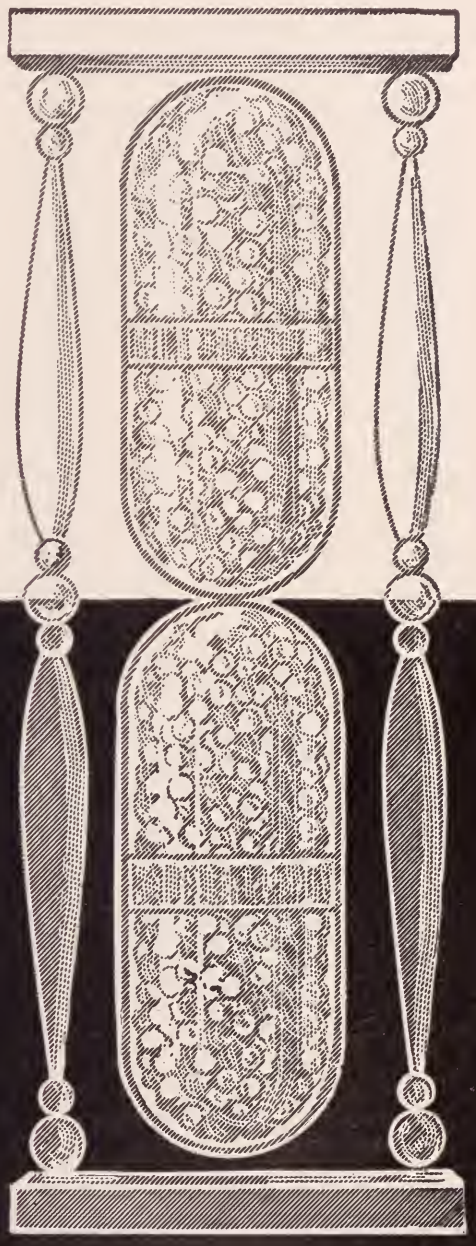
[1] Douglas, H. S.: West. J. Surg. 59:238 (May) 1951.

BURROUGHS WELLCOME & CO. (U. S. A.) INC., Tuckahoe, New York

True S-U-S-T-A-I-N-E-D Action in Steroid Therapy

PREDLON™
PELSULES*
prednisolone

Only 2 Pelsules Daily
Maintenance Dose



- Better therapeutic response
- Reduced daily dosage
- Fewer side effects
- Greater safety, convenience and economy

Now, for the first time, the benefits of steroid therapy are enhanced by sustained release PREDLON PELSULES.

USES: Rheumatoid arthritis, disseminated lupus erythematosus, allergic diseases, and other conditions where the use of steroids is indicated.

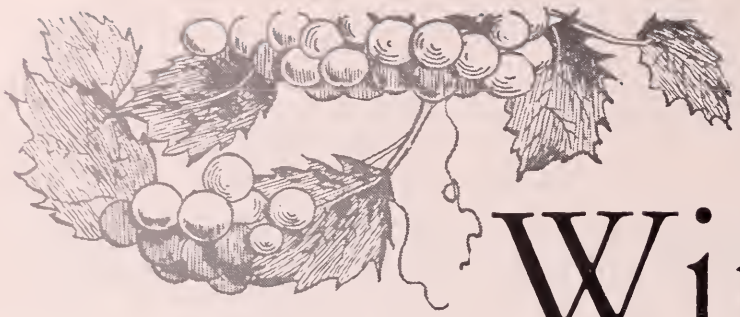
SUPPLY: PREDLON 5 mg. is available in bottles of 30 and 100 Pelsules.

DRUG Specialties INC.

Samples and Literature on request

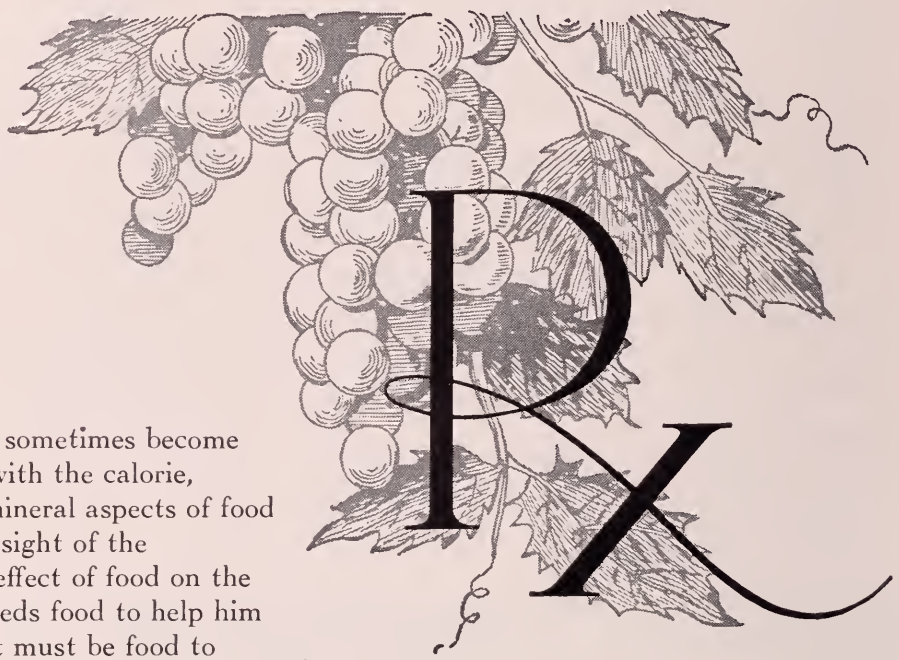
WINSTON-SALEM 1, NORTH CAROLINA

*trademark for timed disintegration capsules



Wine

Brings Harmony to a Meal and Helps Stimulate Depressed Appetites



"Dietitians sometimes become so concerned with the calorie, vitamin and mineral aspects of food that they lose sight of the psychological effect of food on the patient. He needs food to help him get well, but it must be food to intrigue his interest and appetite."*

In the dull and often unappealing dietary regimen of many patients, a glass of wine frequently provides a touch of interest and "elegance"—a psychological boost of inestimable value.

Moreover, wine can be used in cooking to add zest, sparkle, subtle flavor and appetite-appeal to soups, sauces, chicken, meat, fish, eggs and desserts.

By stimulating appetite, supplying quick energy source, relaxing tensions and increasing morale, the prudent use of wine has been described as balm for the convalescent and "milk" for the aged.

For a scientific discussion of the modern Rx uses for wine in convalescence, cardiology, urology, geriatrics, write for "Uses of Wine in Medical Practice," Wine Advisory Board, 717 Market Street, San Francisco 3, California.

*Floore, F. B.: Wine is Fine for Hospital Cookery, Mod. Hosp. 94:134 (June) 1960.

Aluscop
CAPSULES

ANTICHOLINERGIC • ANTISECRETORY • ANTI-ENZYME • ANTACID

with a medical splint



Aluscop capsules, a unique preparation equally as effective as the liquid form, provide rapid and prolonged relief of pain, discomfort and dysfunction in the management of peptic ulcer, hyperacidity, gastro-intestinal spasm or hyperirritability.

Aluscop TREATS THE ENTIRE DYSPEPTIC SYNDROME

- **Methscopolamine nitrate**—the most potent antisecretory agent—35 times that of atropine sulfate, inhibits gastric acid secretion and acts as a "medical splint" through its visceral antispasmodic action.
- **Dihydroxy aluminum aminoacetate and magnesium hydroxide**—two of the most effective antacids—exert dual action without constipating effect.
- **Sodium lauryl sulfate**—a pepsin inactivator—minimizes pepsin erosion and further destruction of tissue to hasten healing of lesions.

Composition: 1 tablespoonful (15 cc.) of suspension or 2 capsules contain: methscopolamine nitrate 2.5 mg., dihydroxy aluminum aminoacetate 900 mg., magnesium hydroxide 75 mg., and sodium lauryl sulfate 40 mg.

Dosage: 1 tablespoonful or 2 capsules after each meal and at bedtime, as required.

Supplied: Bottles of 100 capsules and 12 oz. of suspension.

Lloyd, Dabney & Westerfield, Inc.
Cincinnati, Ohio
Fine Pharmaceuticals Since 1894



A HOUSE CALL ECG TEST demands a lightweight, yet rugged and accurate instrument you can carry anywhere. *The Sanborn "300 Visette" weighs 18 pounds complete, is little larger than your briefcase, performs accurately trip after trip.*

. . . In your office or laboratory, a 2-speed, highly versatile ECG can be one of your most valuable diagnostic tools. *The Sanborn "100 Viso" records at 25 or 50 mm/sec., at any of 3 sensitivities, accepts non-ECG inputs and output monitoring equipment.*

And in clinic or hospital use, an ECG with all its accessories that can be rolled effortlessly from place to place saves time, lets one instrument answer many calls. *The Sanborn "100M Viso" — a mobile cabinet version of the "100 Viso" — provides complete mobility in a precision ECG.*

Call or write your nearby Sanborn Branch Office or Service Agency for complete instrument information and details of the 15-day trial plan and convenient time payment purchase arrangement.

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ST. PETERSBURG *Resident Representative*
1221 Arlington Ave. N., St. Petersburg 7-3229

Dosage: 2 Tablets B.I.D. (A.M. & P.M.)

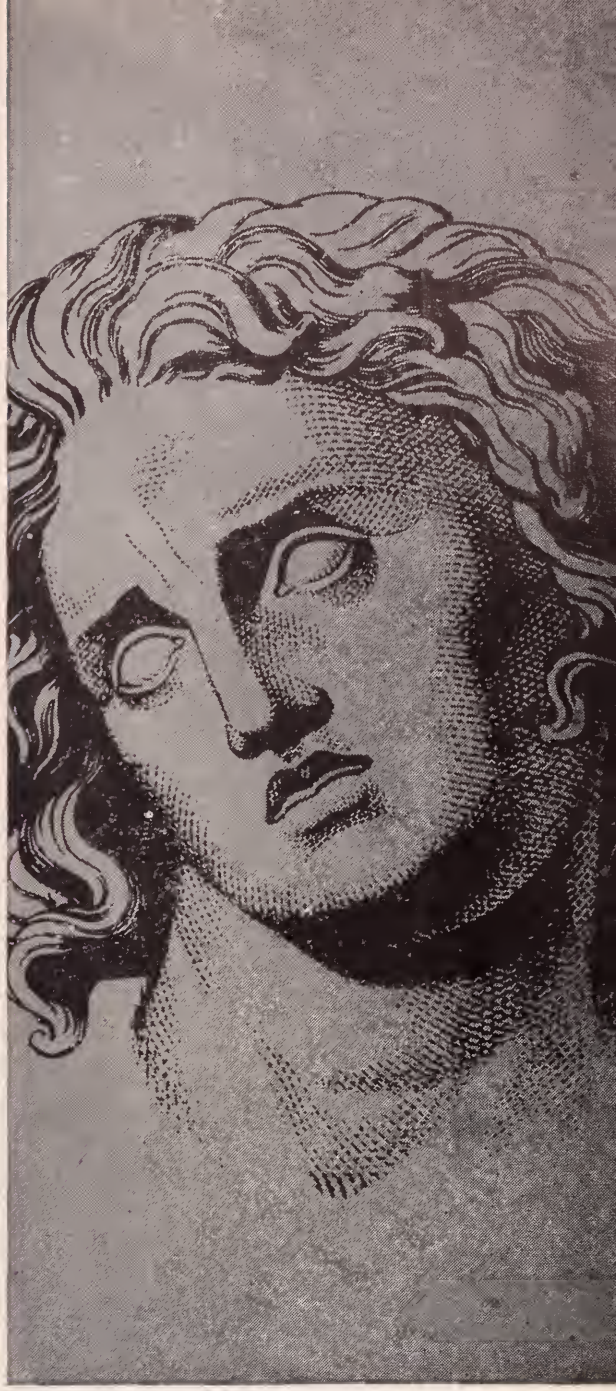
[redacted]

in premenstrual tension

only neo Bromth

treats the whole syndrome





It was the introduction of neo Bromth several years ago that created such widespread interest in the premenstrual syndrome—because of neo Bromth's specific ability to prevent the development of the condition in the first place.

The action of neo Bromth is not limited merely to control of abnormal water retention, or of nervousness, or of pain—or any other single or several of the multiple manifestations characteristic of premenstrual tension. neo Bromth effectively controls the *whole* syndrome.

neo Bromth is also completely free from the undesirable side effects associated with such limited-action therapy as ammonium chloride, hormones, tranquilizers and potent diuretics. neo Bromth has continued to prove to be the safest—as well as the most effective—treatment for premenstrual tension.

Each 80 mg. tablet contains 50 mg. Pamabrom, and 30 mg. pyrilamine maleate. Dosage is 2 tablets twice daily (morning and night) beginning 5 to 7 days before menstruation. Discontinue when the flow starts.

BRAYTEN PHARMACEUTICAL COMPANY • Chattanooga 9, Tennessee

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OBITUARIES

Silas Morgan Copeland

Dr. Silas Morgan Copeland of Jacksonville died in a local hospital on Aug. 20, 1960, after a brief illness. He was 73 years of age.

Dr. Copeland was born in Appling County, Georgia, on Aug. 12, 1887. He received his elementary and academic education in his native state and taught school, served as a principal, became an expert bookkeeper and managed a hotel before embarking upon professional training for the career of his choice. He entered the Atlanta Medical College and as the second highest ranking member of his class received the degree of Doctor of Medicine from that institution in 1915, the year it became the medical department of Emory University.

After serving as a first lieutenant in the Army Medical Corps in World War I, Dr. Copeland entered the general practice of medicine in Surrency, Ga. After he had practiced there for a short time, he came to Florida in 1918 and located in Jacksonville, where he enjoyed a successful career as a general practitioner for 42 years with offices in the St. James Building the entire time. Locally, he was a member of the staff of St. Vincent's, St. Luke's and the Baptist Memorial hospitals and the Duval Medical Center. He was a Mason and a staunch member and a steward of Riverside Park Methodist Church. A baseball fan, he was also a bowling enthusiast and until recently an active participant in Florida's oldest bowling league.

Dr. Copeland was a member of the Duval County Medical Society and held life membership in the Florida Medical Association, having been a member for 41 years. He also was a member of the Southern Medical Association and the American Medical Association. He took great pride in his record of attendance at meetings of the American Medical Association and the Florida Medical Association through the years.

In 1910, Dr. Copeland and Miss Minnie Ross of Surrency were united in marriage. Mrs. Copeland, who preceded him in death in 1946, was through the years an active member of the Woman's Auxiliary to the Florida Medical Association and served as its president in 1941.

Surviving are one son, Hal Ross Copeland, of Tampa; and five daughters, Mrs. James E. Devaney and Mrs. W. Harold Parham, of Jackson-



AHR

PHENAPHEN
(Basic formula)

In each capsule: Phenacetin (3 gr.) 194.0 mg.; acetylsalicylic acid (2½ gr.) 162.0 mg.; hyoscyamine sulfate 0.031 mg.; and phenobarbital (¼ gr.) 16.2 mg.

AHR AHR

PHENAPHEN No. 2

PHENAPHEN with Codeine ..... ¼ gr.

AHR AHR

PHENAPHEN No. 3

PHENAPHEN with Codeine ..... ½ gr.

AHR

PHENAPHEN No. 4

PHENAPHEN with Codeine ..... 1 gr.

SUPPLY: Bottles of 100 and 500 capsules.

sedative-enhanced analgesia

To each "according to his need" — maximum safe analgesia through time-and-pain-tested synergistic formulations, in four strengths for individualized prescription.

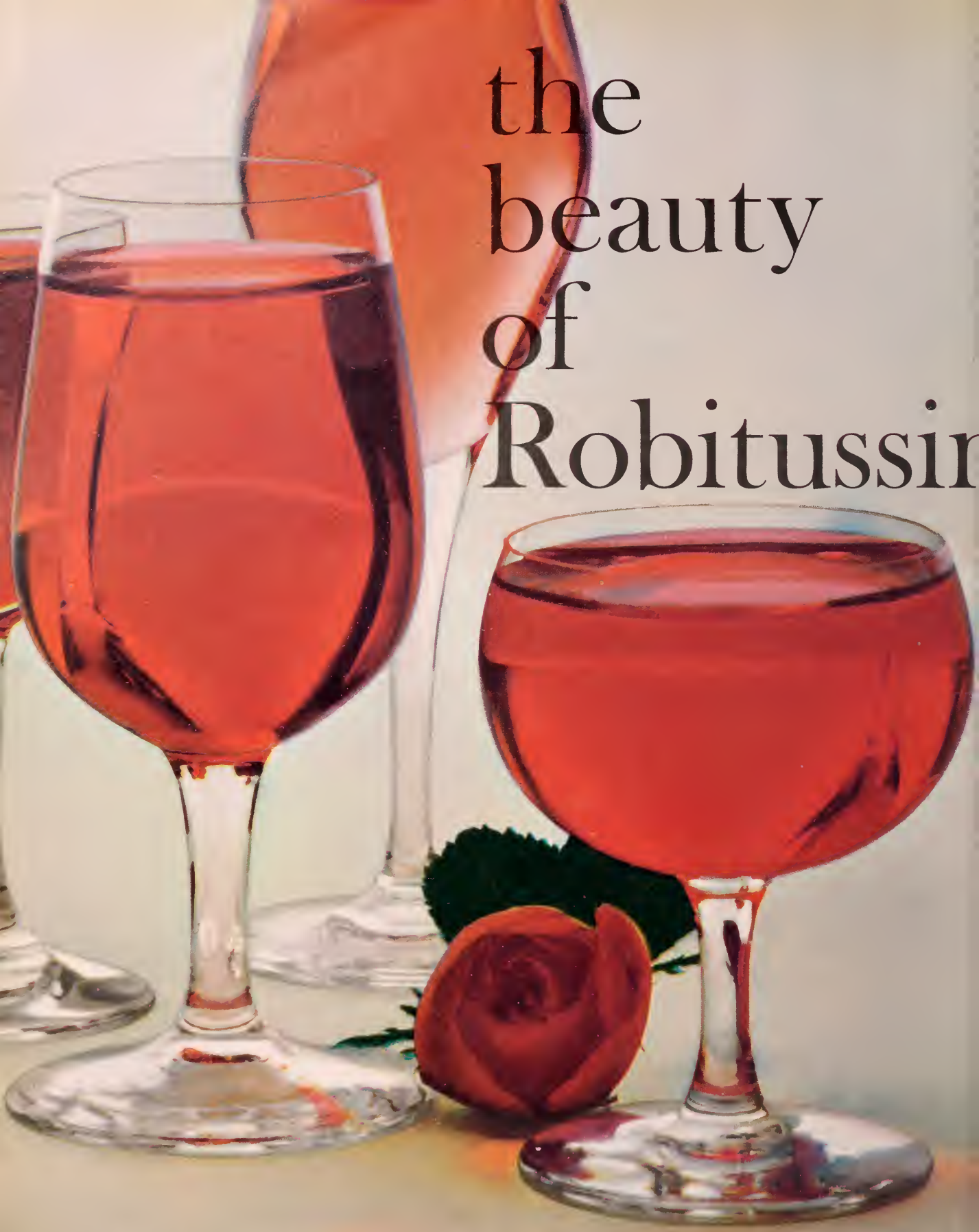
PHENAPHEN® Robins

PHENAPHEN® WITH CODEINE

¼ gr ½ gr 1 gr.

A. H. ROBINS CO., INC., Richmond 20, Virginia

Making today's medicines with integrity . . . seeking tomorrow's with persistence



The real beauty of Robitussin is seen in the relief it brings to cough. By increasing the tracheal flow of respiratory tract fluid, Robitussin's glyceryl guaiacolate turns useless cough into productive cough. Efficient yet gentle, Robitussin helps the cough rid itself of the very irritants that cause it. And in more than a decade of use it has proved unquestionably safe, as well as consistently acceptable, to patients of all ages. Robitussin® is glyceryl guaiacolate, 100 mg. per 5 cc. dose; Robitussin® A-C adds prophenpyridamine maleate 7.5 mg., and codeine phosphate 10.0 mg. per 5 cc. dose (exempt narcotic).

A. H. Robins Company, Inc., Richmond 20, Virginia

ville, Mrs. W. W. Balkcom Jr., of Tampa, Mrs. Travis A. Eason, of Greeneville, Tenn., and Mrs. Fred E. Kurz, of Downey, Calif. Other survivors include five brothers and one sister, all of Georgia, and 13 grandchildren.

Randolph Shevach

Dr. Randolph Shevach of Miami Beach died in that city on Oct. 19, 1960. He was 47 years of age.

Dr. Shevach was born in 1913. He received his medical training at the State University of New York College of Medicine at New York City (Long Island College of Medicine) and was awarded the degree of Doctor of Medicine by that institution in 1936. He then served an internship and residency at Kings County Hospital. He was licensed to practice medicine in Florida in 1939 and located in Miami Beach in 1940. His specialty was internal medicine. He was an associate attending physician on the staff of Mt. Sinai Hospital.

Three years before his initial heart attack, Dr. Shevach started an intensive campaign to promote research in the field of cardiovascular diseases. Today, the Randolph Shevach Memorial Fund for Cardiovascular Research perpetuates his name.

Dr. Shevach was a member of the Dade County Medical Association and of the Florida Medical Association. He also held membership in the American Medical Association and societies of his specialty.

Surviving are the widow, Mrs. Helen Shevach, one son, Allen Shevach, a medical student, and one daughter, Eileen Shevach, all of Miami Beach.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Emmet F. Ferguson Jr. of Jacksonville announce the birth of a son, Emmet F. III, on December 24, 1960.

Deaths — Members

Campbell, Elmer B. Sr., St. Petersburg	December 6, 1960
Knott, Elizabeth M., Ridge Manor	December 8, 1960
Mentzer, Dodge D., Largo	December 16, 1960
Roche, Thomas W., Jacksonville	December 5, 1960
Tippins, Henry L., Miami	November 12, 1960

Deaths — Other Doctors

Brown, Richard L., Fort. Lauderdale	August 16, 1960
Fischer, Frederick, Miami Beach	August 29, 1960
Lobell, Abraham, Burlingame, Calif.	August 7, 1960
Spoto, Beatrice M., Clearwater	December 9, 1960

COMBINED
MEDICAL-ELECTRONIC
RESEARCH UNITS


Activator Model Y-4


U. S. Model 108

Now ready for market following thorough clinical testing. For rehabilitation of face and small muscle groups, post surgical, accidents, palsies and metabolic changes with age, proven value of the newly developed Model Y-4 has been established. Likewise, the supreme value of Ultrasonic energy as a decongestant (well known) in painful and inflammatory conditions of facial and sinus areas, can now be accomplished by the specially designed U.S. Model 108. Both portable for physicians' office or can be carried in his bag. Both represent a new contribution to all branches of medicine and surgery. Manufactured by renowned Zeigler Electronics Company.

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Available only to physicians for their distribution—

Complete Cholesterol Depressant Menus and Recipe Book

A new, authoritative patient-aid . . . for professional distribution only

Now available for use in your practice from The Wesson People . . . easy-to-use manual of 40 pages, including all necessary diet instructions . . . menus, recipes, shopping and cooking guidance . . . all worked out for you . . . so arranged and printed that you have only to check the desired daily calorie level before giving the book to your patient.

You will find this book invaluable for treating patients with elevated serum cholesterol.

Complete menus for 10 days enable you to prescribe diets which are appetizing, nutritiously adequate and which can exert cholesterol depressant activity. Special attention has been given to constructing the menu patterns so that they adhere as closely as permissible to the patient's normal eating habits.

NRC Standards fulfilled. Each menu has been calculated to provide the proper daily allowance of proteins, vitamins and other nutrients as recommended by the Food and Nutrition Board of the National Research Council.

Weight control is achieved as each day's menu is given at 3 calorie levels—1200, 1800 and 2600 calories. You prescribe the level most desirable and modify as desired.

Variety and appetite appeal for patient are built into the menu plan to an extent not previously accomplished. Alternate choices for main dishes minimize monotony, encourage the patient to follow closely the menu plan you specify.

Complete recipes—65 in all—are included to assure that the specified menus provide prescribed levels of calories, the pre-determined ratio of poly-unsaturated to saturated fat, plus essential nutrients.

Dietary fat is controlled so that approximately 36% of the total calories are derived from fat and at least 40% of these fat calories are from poly-unsaturated components (linoleates) as found in pure vegetable oil. The replacement of saturated dietary fat by this percentage of poly-unsaturated fat has been found in clinical studies most effective in the reduction of serum cholesterol and in its maintenance at desirable levels. More liberal menus are provided for maintenance after the patient's progress indicates that desired therapeutic results have been accomplished.

Family meal preparation is simplified. The menus are planned around favorite foods having wide appetite appeal for all members of the household. Patients can entertain in comfort—enjoy cakes, cookies, snacks, prepared with recipes which meet medical requirements.

A high degree of satiety is achieved even at the lower calorie levels, because Wesson provides an unexcelled source of concentrated, slow-burning food energy.

Adaptable for use with diabetics. Carbohydrates have been calculated to fall within the acceptable range for patients to whom a diet planned for diabetes is important. Calories, which must be supplied from fat when the carbohydrate intake is limited, are provided by desirable poly-unsaturated vegetable oil.

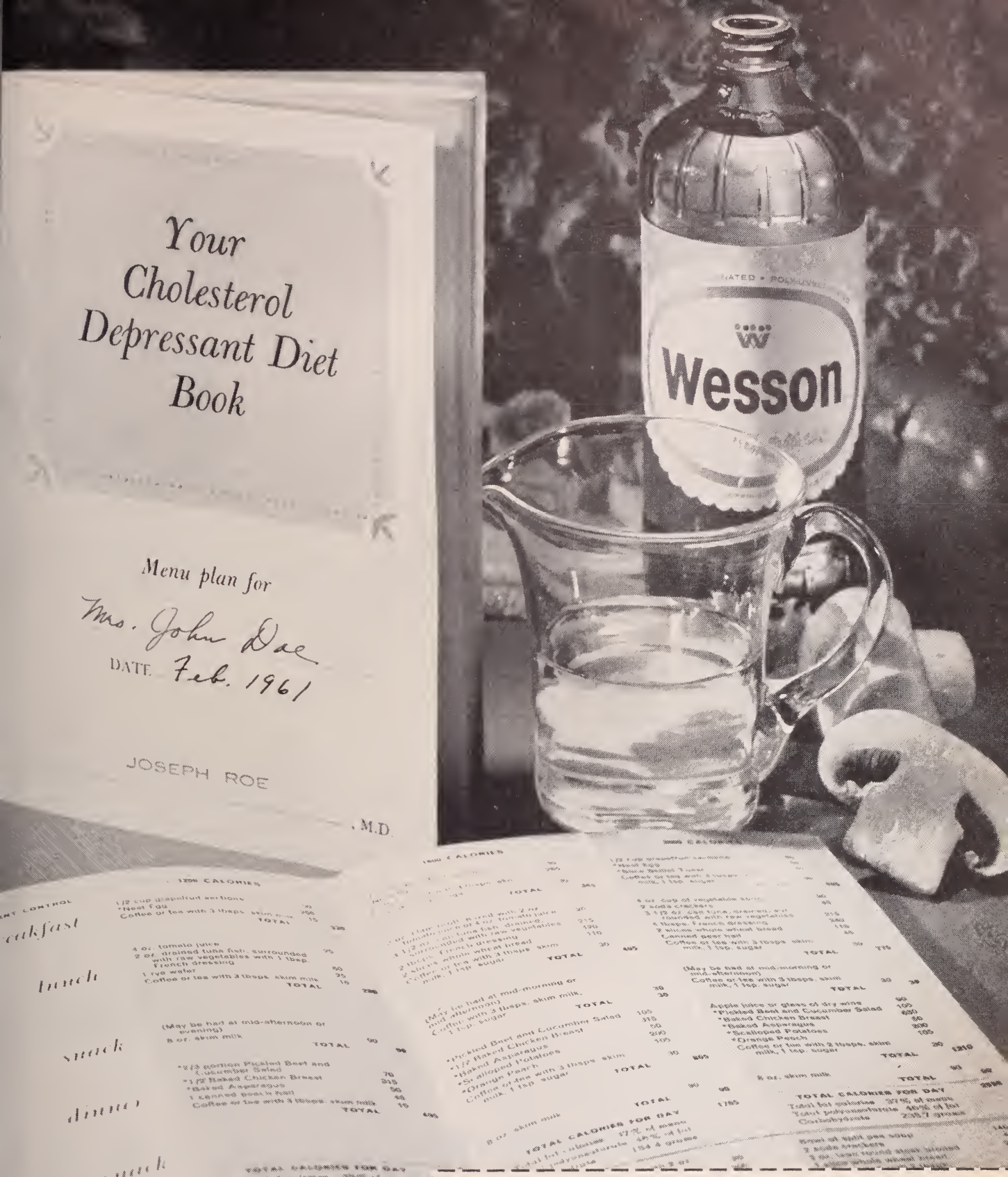
WESSON'S IMPORTANT CONSTITUENTS

Wesson is 100% cottonseed oil—winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	16-20%
Total unsaturated	70-75%
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Ciba Foundation Symposium on Biochemistry of Human Genetics. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Cecilia M. O'Connor, B.Sc. Pp. 347. Illus. 60. Price, $9.50. Boston, Little, Brown and Company, 1959.

In perusing through a hospital library, only a few medical men would sacrifice a second glimpse at this text, because of its title. Many incarcerate words such as biochemistry and genetics into a pigeonhole labeled "Ph.D." But, oh, how wrong are these unfortunate physicians! In these days when doctors are elongating the life

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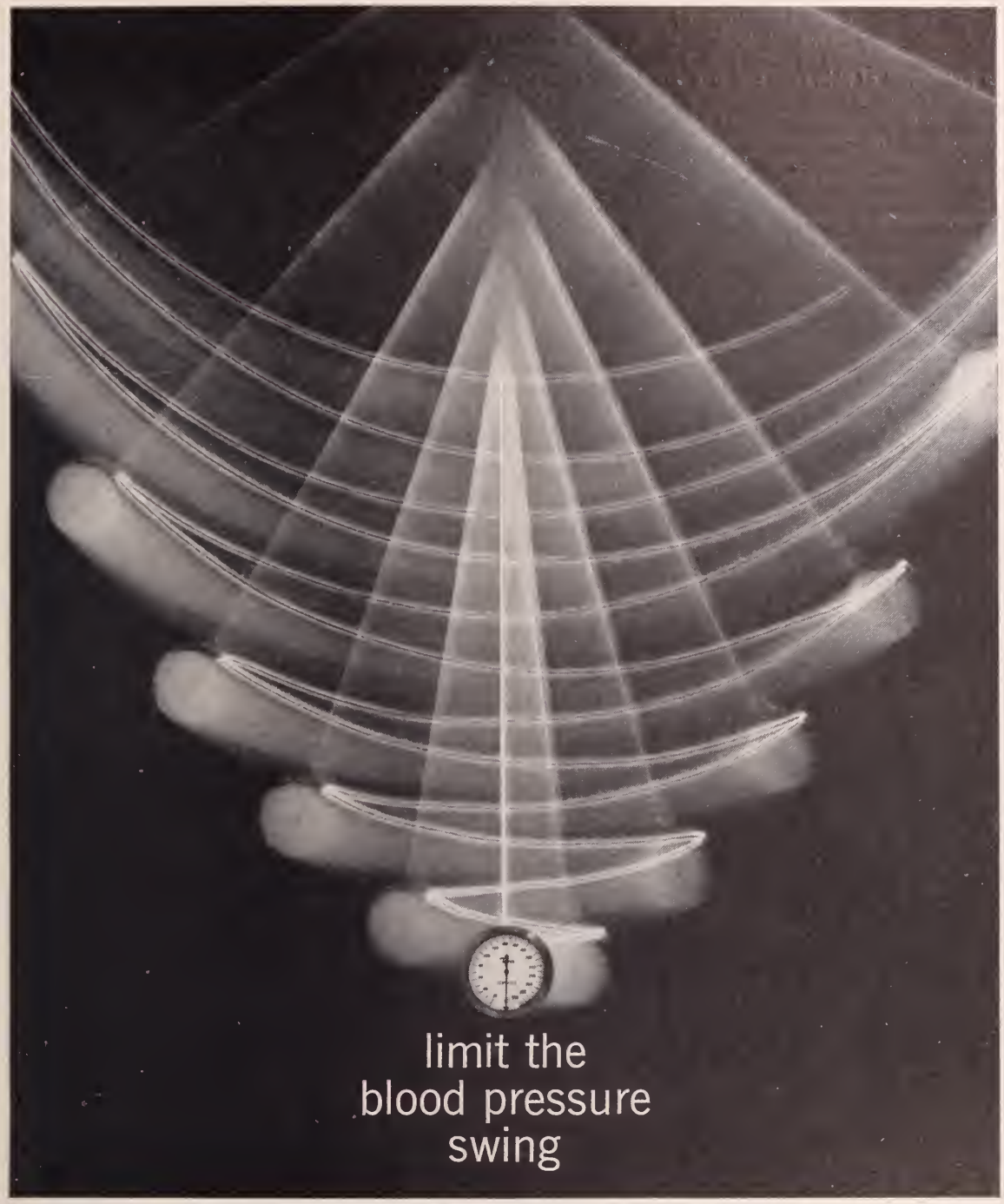
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This writing is a compilation of lectures given by 29 prominent authors participating in a special program sponsored by the International Union of Biological Sciences and presented under the financial auspices of The Ciba Foundation as well as the Rockefeller Foundation. This symposium took place in Naples, Italy, in May 1959. Genetics has passed the age of infancy and now is making its debut into adulthood. Biologists are rewriting their knowledge in terms of biochemistry by discovering new elementary molecular reactions and transforming these to a phenotypic level. It is time we learn why a salamander or a starfish may regenerate an amputated into a new limb, and why the human has not achieved this ability. A gene may be the controlling factor in a specific biochemical reaction, and it is important to be cognizant of these genetical actions. The study of human genetics has been responsible in bringing to light some of the problems of skin color, the metabolic disease known as alcaptonuria, sickle cell anemia, blood grouping, enzyme systems, protein metabolism and familial likeness of relatives. Chromosomal patterns and activities are discussed in some of the lectures presented. Each lecture is followed by an open discussion of the paper which in itself is quite enlightening to the reader. For those in academic medicine this symposium will be very interesting. But, by far, this book will be enjoyed most by the physicians doing skin grafts and organ transplantations, as well as the physician specializing in hematology.

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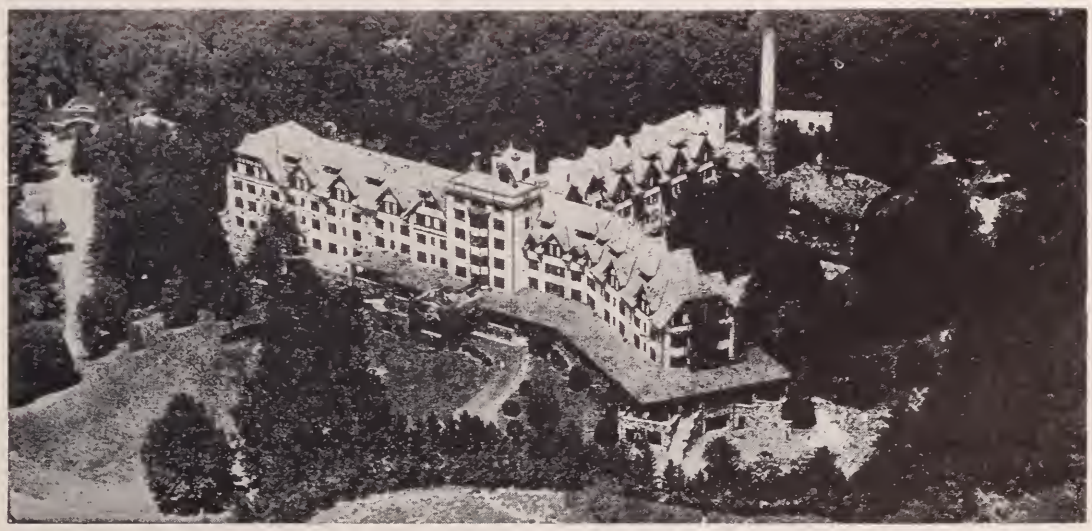
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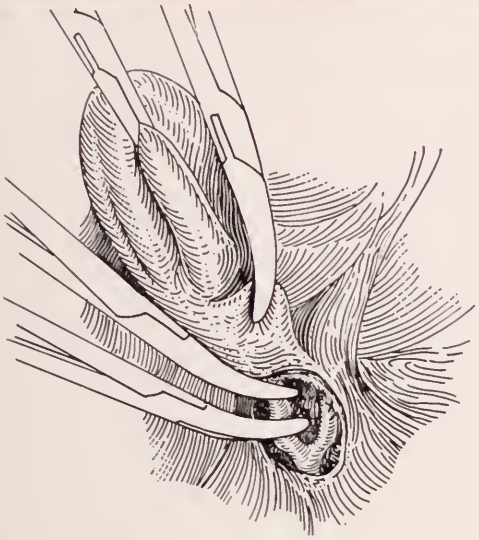
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SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL MEMBERS Associate	Active
Alachua	Raymond J. Fitzpatrick, Gainesville	Richard E. Perry, Gainesville	2nd Tues.		85
* *Bradford, Gilchrist, Union*					
Bay	John J. Hollomon, Panama City	A. Ralph Monaco, Panama City	2nd Tues.		33
Brevard	Willard H. Bennett, Titusville	Frederick H. Lucas, Cocoa Beach	1st Tues.	2	74
Broward	Burns A. Dobbins Jr., Ft. Lauderdale	Frederick W. Fisher, Ft. Lauderdale	4th Tues.	42	267
Charlotte	Carl N. Reilly, Punta Gorda	Stephen R. Roddy, Punta Gorda	2nd Tues.		7
Collier	Loral F. Gwaltney, Naples	Ethel H. Trygstad, Naples	4th Tues.		14
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.		12
* *Baker*					
Dade	Willard L. Fitzgerald, Miami	George W. Robertson III, Miami	1st Tues.	132	1048
DeSoto-Hardee-Glades	Harold S. Agnew, Arcadia	Elmer J. Schmierer, Arcadia	1st Tues.		14
Duval	Sidney Stillman, Jacksonville	Robert J. Brown, Jacksonville	1st Tues.	5	357
Clay	William A. Mulford, Green Cove Spgs.	Joseph G. Ritch Jr., Orange Park			10
Escambia	P. G. Batson Jr., Pensacola	Vernon L. Smith, Pensacola	2nd Tues.	1	119
Franklin-Gulf	William F. Wager, Port St. Joe	Henry I. Langston, Apalachicola	Last Wed.		7
Highlands	Samuel A. King, Avon Park	Claude B. Henderson, Avon Park	3rd Mon.	1	12
Hillsborough	Herbert B. Lott, Tampa	Frank A. Massari, Tampa	1st Tues.	2	264
Indian River	Phil D. Morgan, Vero Beach	Walter W. McCorkle, Vero Beach	2nd Tues.	2	14
Jackson-Calhoun	Terry Bird, Blountstown	Francis M. Watson, Marianna	Quarterly		17
Lake	Lawton F. Douglass, Umatilla	Raymond A. Debo, Eustis	1st Wed.	4	35
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Madison	Julian M. Durant, Madison	A. Franklin Harrison, Madison	1st Tues.	1	6
Manatee	Warren G. Darty, Palmetto	C. Sumner Quimby, Bradenton	2nd Tues.	1	39
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Nassau	Henry B. Dickens Jr., Fernandina Bch.	John B. Britton, Fernandina Beach	1st Thurs.	2	11
Orange	Norman F. Coulter, Orlando	Truett H. Frazier, Orlando	3rd Wed.	36	235
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Polk	John E. Daughtrey, Lakeland	Albert G. King Jr., Lakeland	2nd Wed.	16	131
Putnam	Walter W. Weigel, Palatka	James R. Sayers, Palatka	2nd Tues.		15
St. Johns	S. Raymond Cafaro, St. Augustine	Joseph A. Shelley, St. Augustine	3rd Tues.		17
St. Lucie-Okeechobee-Martin	Joseph H. Batsche, Fort Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.		31
Sarasota	George A. Bishopric, Sarasota	Harry O. Specht, Sarasota	2nd Tues.	8	89
Seminole	Clyde F. B. Smith, Sanford	George H. Starke (Col.), Sanford	2nd Tues.	1	18
Suwannee-Hamilton-Lafayette	Hugo F. Sotolongo, Live Oak	William P. Blackmon, Jasper	1st Sat.		7
Taylor	John A. Dyal Jr., Perry	Charles M. Roberts, Haines City	Last Fri.		5
* *Dixie*					
Volusia	C. Robert DeArmas, Daytona Beach	Thomas W. Ayres, Daytona Beach	2nd Tues.	6	99
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Walton-Okaloosa-Santa Rosa	Allen A. Enzor, Crestview	Albert B. Russell Jr., Ft. Walton Beach	3rd Tues.	4	33
Washington-Holmes	Walter H. Shehee, Chipley	John T. Grace, Bonifay	Quarterly	3	4
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			Grand Total		4,142

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Source: Farris, J. M., and Smith, G. K.: M. Clin. North America *43*:1133 (July) 1959.

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March, 1961
Vol. XLVII - No. 9

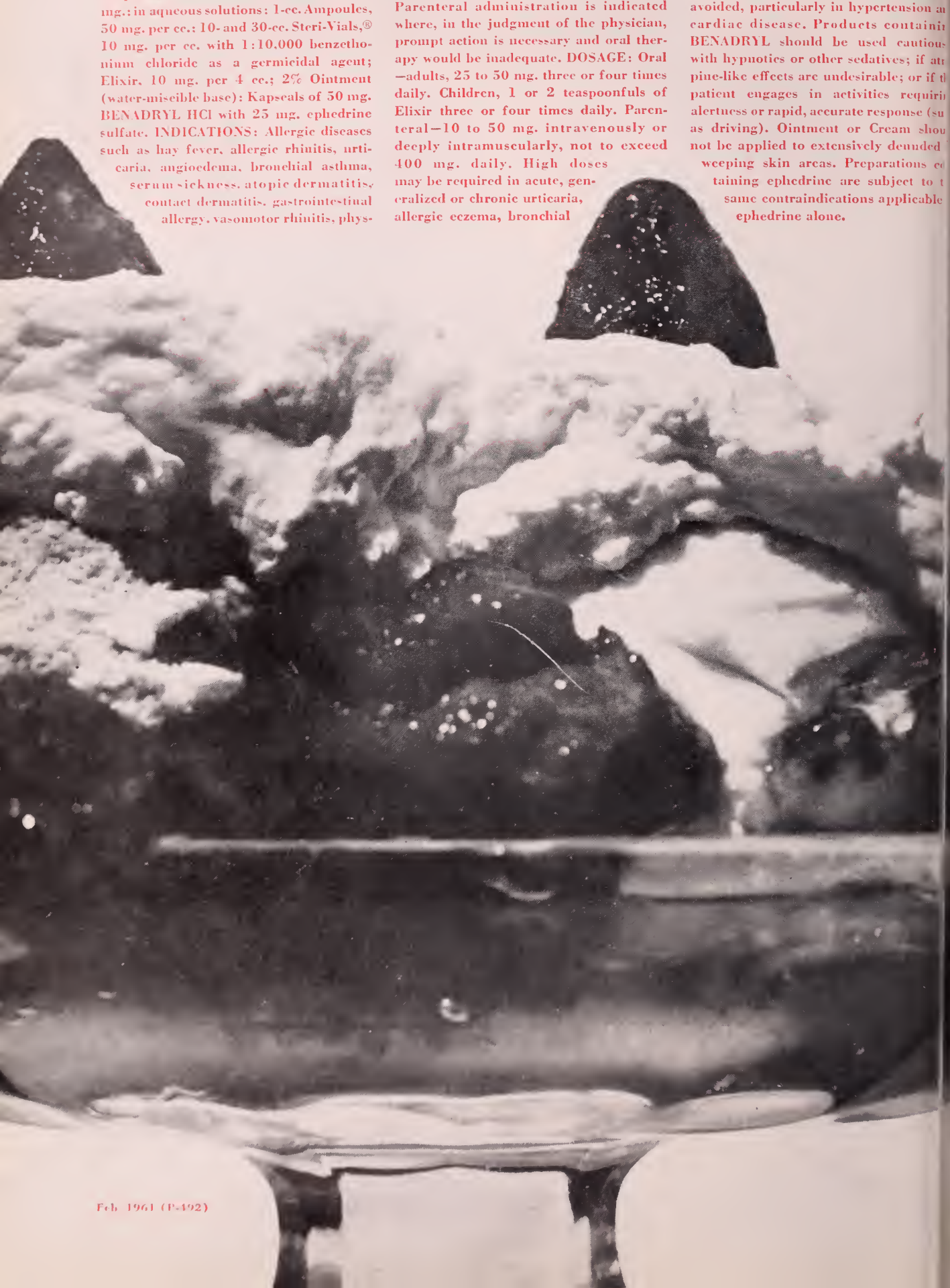
THE Journal OF THE FLORIDA MEDICAL ASSOCIATION



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BENADRYL Hydrochloride (diphenhydramine hydrochloride, Parke-Davis). Kapseals® of 50 mg.; Capsules of 25 mg.; Emplets® (enteric-coated tablets) of 50 mg.; in aqueous solutions: 1-cc. Ampoules, 50 mg. per cc.; 10- and 30-cc. Steri-Vials,® 10 mg. per cc. with 1:10,000 benzethonium chloride as a germicidal agent; Elixir, 10 mg. per 4 cc.; 2% Ointment (water-miscible base): Kapseals of 50 mg. BENADRYL HCl with 25 mg. ephedrine sulfate. INDICATIONS: Allergic diseases such as hay fever, allergic rhinitis, urticaria, angioedema, bronchial asthma, serum sickness, atopic dermatitis, contact dermatitis, gastrointestinal allergy, vasomotor rhinitis, physical allergies, and allergic transfusion reactions, also postoperative nausea and vomiting, motion sickness, parkinsonism, and quieting emotionally disturbed children. Parenteral administration is indicated where, in the judgment of the physician, prompt action is necessary and oral therapy would be inadequate. DOSAGE: Oral—adults, 25 to 50 mg. three or four times daily. Children, 1 or 2 teaspoonfuls of Elixir three or four times daily. Parenteral—10 to 50 mg. intravenously or deeply intramuscularly, not to exceed 400 mg. daily. High doses may be required in acute, generalized or chronic urticaria, allergic eczema, bronchial asthma, and status asthmaticu
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Feb. 1961 (P-492)

when allergy looms large in the life of your patient...

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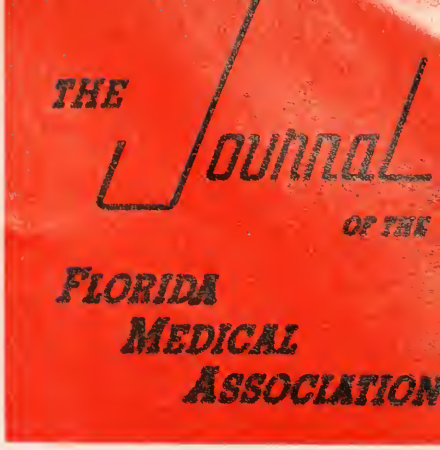
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VOLUME XLVII, No. 9

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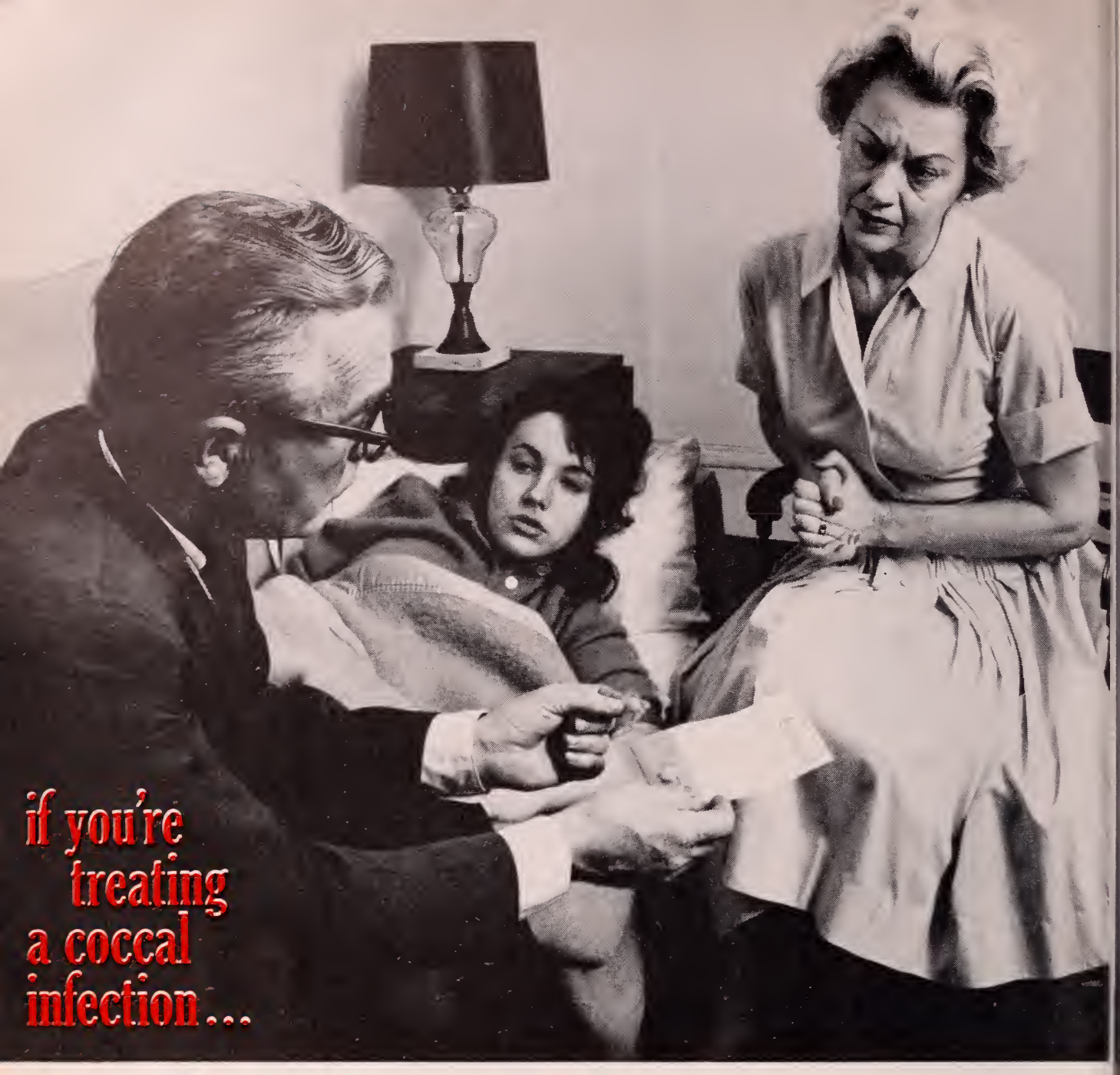
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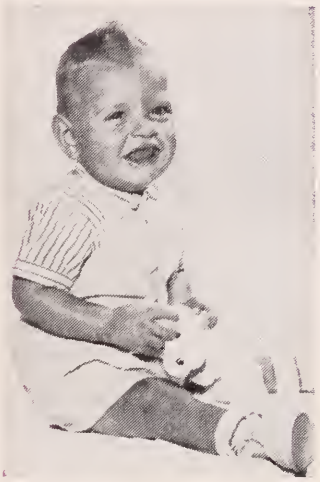
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*Council on Drugs, J.A.M.A. 165:58 (Sept. 7) 1957.

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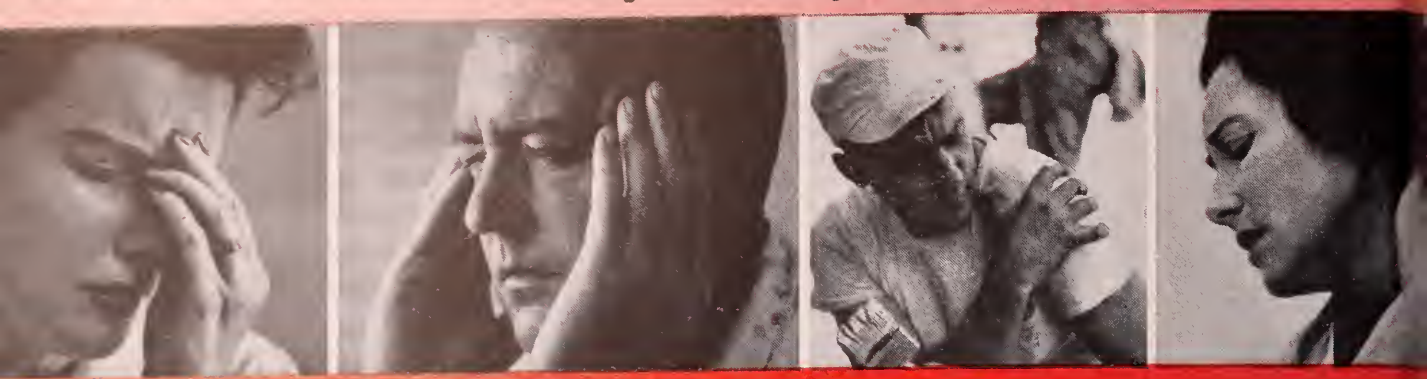
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"nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H. Am. J. Med. 25:662 (Nov.) 1958

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H. Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H. and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W. and Fong, T.C.C. In Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan, G. G.: Diseases of Metabolism, 4th edition, W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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10 Ichthyosis	3	4	3
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1. Weissberg, G.: Clin. Med., June 1960.

2. Spoor, H. J.: N. Y. St. J. Med., Oct. 15, 1958.

**patent pending*
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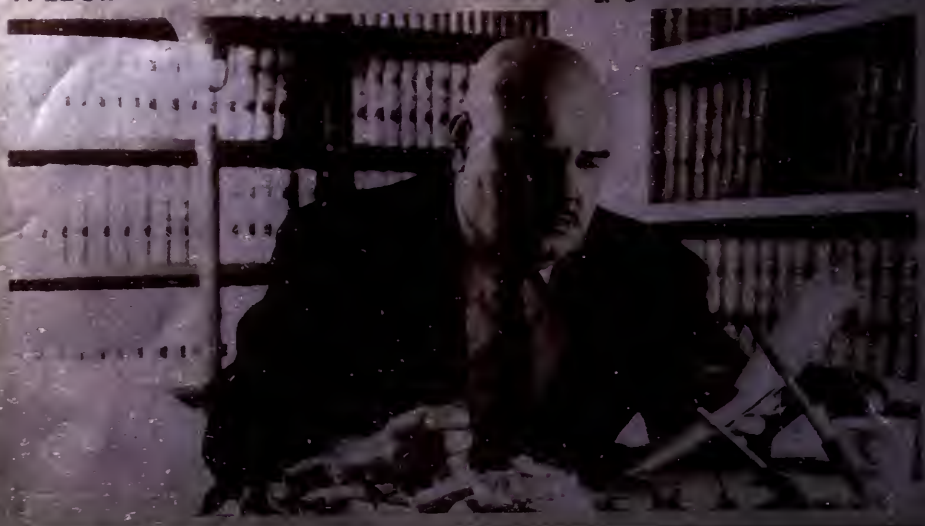
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Aristocort

Triamcinolone has long since proved its unsurpassed efficacy and relative safety in the therapy of *rheumatoid arthritis, inflammatory and allergic dermatoses, bronchial asthma,* and all other conditions in which corticosteroids are indicated. But ARISTOCORT has also opened up new areas of therapy for selected patients who otherwise could not be given corticosteroids. Medicine is now in an era of "special-purpose" steroids.[1]

One outstanding advantage of triamcinolone is that it rarely produces edema and sodium retention.[1,2]

The clinical importance of this property cannot be overemphasized in treating certain types of patients. McGavack and associates[3] have reported the beneficial results with ARISTOCORT in patients with existing or impending cardiac failure, and those with obesity associated with lymphedema. Triamcinolone, in contrast to most other steroids, is not contraindicated in the presence of edema or impending cardiac decompensation.[3]

Hollander[1] points out the superiority of triamcinolone in not causing mental stimulation, increased appetite and weight gain, compared to other steroids which produce these effects in varying degrees. And McGavack,[2] in a comparative tabulation of steroid side effects, indicates that triamcinolone does not produce the increased appetite, insomnia, and psychic disturbances associated with other newer steroids.

ARISTOCORT can thus be advantageous for patients requiring corticosteroids whose appetites should not be stimulated, and for those who are already overweight or should not gain weight. Likewise, ARISTOCORT is suitable for the many patients with emotional and nervous disorders who should not be subjected to psychic stimulation. Furthermore, ARISTOCORT Triamcinolone, in effective doses, showed a low incidence of side reactions and is a steroid of choice for treating the older patient in whom salt and water retention may cause serious damage.[2]

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Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. Dosage should be individualized and kept at the lowest level needed to control symptoms. It should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

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Concepts of Respiratory Disease in Children

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No group of diseases to which man is susceptible results in as much discomfort, economic loss, and morbidity as that affecting the respiratory tract. Sixty to 70 per cent of all illnesses, particularly in children (table 1) fall into this category. Children share with the elderly a high incidence of medically significant complications and consequent high mortality rates. Most respiratory disease in the young, however, is mild, the child being less annoyed than his parents by his hacking night cough and dripping nose. The physician who sees children is called upon to manage more respiratory disease than any other illness; accordingly, it appears appropriate from time to time to stand back and attempt to gain a perspective of a group of illnesses that by numbers of daily contacts alone may provide the trees which obscure the forest.

Curiously, the bases for gaining this perspective are not easily available to the casual medical reader. The current clinical literature scarcely reflects the over-all import of these diseases. The explanation lies both in the great emphasis on antibiotic management of regional disease (such as tonsillitis) in the clinical literature and in the fact that recent rapid development of basic knowledge of etiologic agents responsible for most respiratory illness has not had time for clinical assessment. Though clinical investigation has not kept pace with the rapid gains in knowledge, particularly of the newer viral agents, patterns are beginning to emerge that allow a tentative analysis, which, though more hypothesis than conclusion, may provide the clinician a useful framework of reference in his practice. From such an evaluation a number of concepts emerge; these will be discussed:

Concept of the Diversity of Etiologic Agents Producing Similar Respiratory Illness

Many studies of military, family, and other nonhospital populations have demonstrated that 95 per cent of all acute respiratory disease in children is nonbacterial in etiology. The bacterial agents associated with acute respiratory disease with any frequency are almost limited to the 50 strains of the group A Streptococcus. Much excellent investigative work has been devoted to the diagnosis, management, and sequelae of Streptococcal infections, though they account for a very small proportion (estimated to be on the order of 5 per cent) of all respiratory illness in children.

Of the nonbacterial causes of respiratory disease in children only an estimated 10 to 15 per cent can now be accounted for on the basis of known viral agents. Moreover, this list has grown from 1 per cent to 10 to 15 per cent only in the past five years. The remainder—more than 80 per cent—are presumably viral in etiology, but have not been definitely associated with agents.

Most respiratory disease has similar clinical manifestations, *regardless of etiology,* bacterial or viral, including the signs and symptoms listed in table 2, familiar to layman and physician alike. These are given in the interest of definition, since the burden of this discussion depends on such broad limits in categorizing respiratory disease

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as it occurs in human populations.* All of the viral agents listed in table 3, and the "common cold" agents produce this sign-symptom complex in a way which, in the great majority of children, gives the physician little evidence upon which to base an etiologic diagnosis. Even group A streptococcal pharyngitis is in most children impossible to distinguish from exudative pharyngitis due to adenovirus, for example, without an adequate throat culture.

These similarities in manifestations preclude an accurate differential diagnosis on clinical grounds alone; however, certain features peculiar to the agent and to the epidemiologic circumstances may allow, with experience, an increasingly educated guess as to the responsible agent in any given child with a respiratory illness.

Most physicians find that their greatest asset in this regard is the wise use of what might be called their private epidemiologic intelligence in assessing the general nature, course, and prognosis (as well as bacterial *versus* viral) of any given respiratory disease of children in their community. The wise and time-honored use of this knowledge of "what's around" should be based upon the confidence gained by the physician through careful clinical, laboratory, and bacteriologic evaluation of early cases occurring in any given epidemic. In this way he finds that a given pattern of respiratory illness is, or, most commonly, is *not* associated with a bacterial agent which will require antibiotic therapy. He can then with confidence manage respiratory disease of probable viral origin without antibiotic therapy in the absence of complications.

An additional guide to etiologic diagnosis is provided by some knowledge of the clinical expression of the known agents, which may have at least some clinical features which serve to distinguish them. If these features are not recognized in the patient himself, they may be evident on inquiry in other members of the family or community with sufficient frequency to be helpful. These will be reviewed briefly.

Group A Streptococcus

Though the clinical manifestations of streptococcal disease depend greatly upon the age of the child, the occurrence of (1) exudate on the tonsils, (2) regional adenopathy, (3) absence of hoarseness, and (4) elevated leukocyte count in the febrile child with respiratory disease favors this diagnosis. The only positive diagnostic method is a properly taken throat culture. This can now easily and inexpensively be performed in the physician's office through the use of a commercially prepared sheep blood agar plate. Interpretation of the presence or absence of beta hemolytic colonies after 24 hours' incubation can be made by any physician after minimal experience. In the experience of an increasing number of practicing physicians this is not only a very acceptable procedure to most patients, but satisfying to the physician in that he knows what he is treating. Further, in the absence of suppurative complications it has been well demonstrated that treatment given up to 10 days after the onset of symptoms still prevents rheumatic fever. Furthermore, the *symptomatic* course of acute streptococcal

*No attempt has been made to include primary respiratory disease due to fungi, tubercle bacilli, diphtheria, pertussis, or related and unusual disorders.

Table 1. — Illnesses Resulting in Absence From School

Respiratory conditions	67.6%
Infections, parasitic diseases	14.3%
Injuries	4.8%
Digestive disturbances	2.8%
All other	10.5%

Table 2. — Manifestations of Acute Respiratory Disease in Children

1. Rhinorrhea, coryza
2. Pharyngeal soreness
3. Erythema of pharynx
4. Follicular tonsillitis
5. Fever
6. Dry cough
7. Rhonchi in chest
8. Erythema of palpebral conjunctiva

Table 3. — Known Viral and Bacterial Agents Producing Acute Respiratory Disease in Children

Group A Hemolytic Streptococci (50+ types)

Myxoviruses
Influenza, types A, B, C,
Para-influenza, types 1, 2, 3

Adenoviruses (20+ types)

Enteroviruses
Poliovirus
Coxsackie A (10 types)
Coxsackie B
ECHO viruses (20+ strains)

Miscellaneous Viral Agents

"CCA"	"2060"	"Coe"
"CA"	"J.H."	"P.A.P."

Table 4. — Comparison of Per Cent Reduction in Certain Symptoms of Proved Group A Streptococci Respiratory Disease in Penicillin-Treated and Untreated Patients
(After Brink, et al., 1951*)

Symptom	Day or Hour of Disease	Per Cent with Symptoms: Penicillin Group (70 Patients)	Per Cent with Symptoms: Control Group (81 Patients)
Fever over 100 F.	8 hours	70	68
	16 hours	35	35
	24 hours	13	26
	32 hours	5	27
	40 hours	2	5
Sore throat	1 day	85	92
	2 days	84	85
	3 days	53	65
	4 days	27	34
	5 days	10	20

*Brink, W. R.; Rammelkamp, C. H.; Denny, F. W.; and Wannamaker, L. W.: Effect of Penicillin and Aureomycin on Natural Course of Streptococcal Tonsillitis and Pharyngitis, Am. J. Med. 10:300-308 (March) 1951.

respiratory disease is not significantly improved by penicillin therapy (table 4). Its rationale lies almost entirely in its efficacy in treating suppurative complications, and in eradicating the carrier state which prevents glomerulonephritis and rheumatic fever. To insure prevention of the latter, eight to 10 days of coverage are required, an end which may be achieved in several ways.

Adenoviruses

This group of viruses, consisting of more than 18 immunologically recognizable types recovered from humans, affects all ages and populations. Types 1, 2, 3, 5, and 14 are those which are most frequently associated with respiratory disease in children. Clinical features commonly observed with this group of agents are fever, pharyngeal erythema, sore throat, which in some outbreaks seems out of proportion to appearance, and the common finding of follicular conjunctivitis of varying degrees of severity. This agent is most frequently encountered in cold weather, coinciding with the streptococcal season, and compounding the diagnostic problem. Some outbreaks have been associated with exudative pharyngitis and tonsillitis indistinguishable from that usually thought diagnostic of group A streptococcal origin. Polymorphonuclear leukocytosis occurs much less frequently in adenovirus infection than in group A streptococcal infection; in the absence of a throat culture this point may assist in differentiating the two.

Myxo Viruses

This group includes those viruses which have, among other characteristics, an affinity for certain mucopolysaccharides—the human agents including the influenza group, para-influenza group, and mumps. The clinical manifestations distinguishing influenza virus infection are familiar, usually featuring a predominance of systemic symptoms such as fever and chills. The para-influenza viruses (1, 2, 3) include the groups formerly known as hemadsorption viruses and the Sendai pneumonitis virus of infants. These have been isolated from children with the common cold and more characteristically, with the clinical manifestations of croup. They have been isolated repeatedly with this latter clinical pattern.

Enteroviruses

Though not generally thought of as primary respiratory viruses, this ubiquitous group may produce respiratory manifestations indistinguishable from those mentioned and in particular can be associated with the "grippe." They are most frequently isolated from the intestine, where the primary infection is assumed to exist, and occur primarily in the warm seasons rather than in the winter.

Polio Virus produces undifferentiated upper respiratory disease with or without fever commonly in children, the aseptic meningitis and paralysis being infrequent secondary or complicating manifestations.

Coxsackie A Virus Group is comprised of over 10 types with clinical manifestations ranging from undifferentiated febrile respiratory disease with or without a rash, and herpangina (A2, 4, 5, 6, 8, 10) with the typical vesicular pharyngitis in children, to aseptic meningitis (A7, 9). The occurrence of a morbilliform rash and vesicular stomati-

Table 5. — Immunity to Reinfection to the "Common Cold"
(After Jackson, et al., 1959*)

Volunteer Group	Number	Results of Inoculation of Secretions from Infected Donor to Recipient		
		Sequence	Got "Cold"	Per Cent Got "Cold"
Single inoculation	660		287	43
Two inoculations *same* donor material	144	Result of first inoculation	71	49
	141	Result of second inoculation	13	9
Two inoculations *different* donor material	115	Result of first inoculation	74	35
	115	Result of second inoculation	65	43

*Jackson, G. G., and Dowling, H. F.: Transmission of Common Cold to Volunteers Under Controlled Conditions. IV. Specific Immunity to Common Cold. J. Clin. Invest. 38:762-769 (May 1959.

Table 6. — Common Complications of Viral Respiratory Disease With Usual Bacterial Etiology of Each

1. Otitis media	a. Pneumococcus b. Group A Streptococcus c. H. influenzae, type B d. Staphylococcus
2. Pneumonia	a. Pneumococcus b. Staphylococcus c. ? H. influenzae, type A
3. Sinusitis, chronic runny nose syndrome	a. Pneumococcus b. Group A Streptococcus c. Staphylococcus
4. Cervical adenitis	a. Group A Streptococcus b. Staphylococcus 3. H influenzae, type B

tis or pharyngitis particularly raises suspicion of infection with this group of agents.

Coxsackie B Group has a range of clinical manifestations from undifferentiated febrile flu-like illness through pleurodynia, encephalomyocarditis, aseptic meningitis, and encephalitis. Respiratory manifestations are less frequent.

ECHO Viruses are a group of over 20 agents producing disease mostly in the warm months which have been associated with a wide range of clinical disease including undifferentiated respiratory illness with fever, with or without diarrhea, diarrheal disease alone, exanthematous illnesses ("Boston exanthem"), aseptic meningitis, and encephalitis.

"Common Cold" Virus.—The search for the agent for the common cold has been as difficult and embarrassing as finding the "abominable snowman" and perhaps as futile. Much evidence now exists to indicate that there are many common cold viruses, each immunologically specific, and therefore capable of inducing an infection in the susceptible nonimmune child. This group, though causing disease similar to that produced by the other agents, have never been isolated through use of animals or tissue cultures. To date, the common cold can only be studied through the use of the human volunteer, which has compounded the difficulties in assessing the role of any particular agent. The best available current studies appear to be those of Jackson and his colleagues who inoculated nasal secretions from actively infected to healthy volunteer student nurses and produced "colds" in up to 50 per cent of recipients. He has shown through such studies, as outlined in table 5, that there are multiple distinguishable agents in the population at any given time, enabling one to acquire that number of "colds" if nonimmune and appropriately exposed.

Other Viral Agents

Among as yet unclassified viruses which have been isolated from children with acute respira-

tory illnesses are the J.H. virus, the 2060 virus, the Coe virus, and the P.A.P. agent. This last agent is believed to be associated with cold agglutinin positive, MG-agglutinin-positive atypical pneumonia.

Concept of Differentiation of Primary Respiratory Disease from Complications

As has been stated and amplified, most respiratory illnesses occurring in adults and children are of nonbacterial etiology, and as such, neither require nor are benefited by antibiotic therapy. In the extremes of life, however, and particularly in children, the complications of nonbacterial respiratory illnesses are frequent causes of morbidity and mortality and these often *do* require appropriate antibiotic therapy. Conceptually, it appears sound to look upon viral respiratory disease as producing alterations in physiologic mechanisms or obstructing drainage of the ear, sinus, or bronchus. This altered state allows whatever potentially virulent bacterial agent the child may be carrying to multiply and result in bacterial infection of the middle ear, sinuses, lower respiratory tract or cervical lymph nodes. Practically, the onset is usually heralded by a change in the otherwise convalescing or nearly well child; that is, increase in fever previously waning, pain in the ears, and lower respiratory symptoms or signs. These are clues the properly instructed mother knows require the further attention of the physician, and by which the physician knows that a complication of the viral respiratory disease he has been managing conservatively now may require therapy.

The bacterial agents which are found most frequently associated with these common complications of viral respiratory disease are shown in table 6. Otitis media, still by far the most frequent and significant of these in children, in most cases is the result of pneumococcal or group A streptococcal infection; however, an increasing number, in my experience, result from staphylococcal infection. The "runny-nose" syndrome—the little one with two ropes of mucopurulent material dripping down his upper lip—in toddlers, familiar to all, is most frequently the result of pneumococcal or staphylococcal infection. The latter more frequently results in crusting and local irritation on the upper lip. Cervical adenitis and peritonsillar abscesses are much less frequent than observed in past years. When it occurs, it is most often unilateral, associated with moderate pain, but extreme tenderness. In the small child, it may result in stiffness of the neck simulating meningeal irritation.

The treatment of each of these complications ideally is somewhat different in principle. In all, however, the most common error made is too brief a period of antibiotic therapy. For example, the Group A Streptococcus requires an eight to 10 day course of therapy to achieve an 80 per cent reduction in carrier state; recurrences are common with lesser periods and may result in the familiar "ping-pong" phenomenon. In this, a child and his siblings appear to have recurrent infections when in reality they are passing back and forth a single one by virtue of brief treatment periods. Here, suboptimal treatment simply inhibits immunity and permits recurrence of the carrier state or reacquisition of one agent from a carrier sibling.

The wrong choice of antibiotic for treatment has caused little difficulty in the past, but with the emergence of resistant strains and the increase in the prevalence of staphylococcal complications or respiratory disease, this may become more of a problem in the future. When a culture of the nasopharynx (the predominant flora there gives strong indication of the complicating bacterial agent) is taken upon starting therapy, the physician can know what he is treating and make any changes if required 24 to 48 hours later.

Although culture results cannot substitute for clinical judgment, their use can be shown to be less expensive and better for the patient than several changes of antibiotics when resistant infection is unexpectedly encountered. For example, otitis media or cervical adenitis due to *Hemophilus influenzae* will not respond to penicillin therapy. Many staphylococcal infections will not respond to penicillin or tetracycline treatment.

Concepts of Antibiotic Therapy in Primary Respiratory Disease

Often the physician must decide when to treat a primary respiratory disease in the *absence* of complications. Affirmative judgments in this situation are responsible for the bulk of antibiotic therapy given in America today. Unfortunately, the data on which to base sound judgments are most often missing in the office or at the bedside.

Since immediate treatment is a matter of clinical judgment, what are the ingredients which go into this judgment—how is the use of an antibiotic justified? Comfort is scarcely afforded by knowledge that clinical recognition of streptococcal respiratory disease, the only frequent primary

respiratory illness, is at best only slightly greater than chance alone. In the absence of complications, even this infection, if it exists (less than one chance in 20), requires therapy chiefly to prevent rheumatic fever, and a period of grace in which to do this is available that permits the results of careful culture of the throat to establish the need. A frequent justification of immediate therapy of primary respiratory disease is based on the purported prophylactic value of antibiotic therapy in *preventing* complications. Bacterial complications occur infrequently in adults but sufficiently often in children to warrant prophylaxis if it could be shown to be effective. This premise is scarcely supported by the available, albeit inadequate, data. For example, penicillin prophylaxis has been shown to yield no decrease in incidence of bacterial complications of rubeola infections. Complications occurred in the same proportion as in control groups, and when they occurred, were due to penicillin-resistant agents. Similar findings are available in relation to influenza.

Another force affecting the judgment of whether to use antibiotics in primary uncomplicated respiratory disease is, in the opinion of many physicians, patient pressures. The concept of "miracle drugs" has become so commonplace that even otherwise thoughtful and objective parents insist that *their* child get treated with one. Too, the pharmaceutical firms have reinforced these outside pressures by strongly urging the physician to treat primary respiratory disease with antibiotics (or mixtures of these with aspirin and antihistamines) often on inadequate scientific evidence. Brief perusal of journal advertising in the past year documents this pressure fully.

The relevance of these forces which interfere with sound judgment is in the premise that positive harm can result from the excessive or injudicious use of this group of drugs. The complications in individual patients—hypersensitivity reactions, anaphylaxis, superinfection—are well known and sufficiently frequent to be a common experience of physicians. The provision of a population in which resistant strains can select out is now a well documented positive effect of widespread antibiotic use. Less well documented and perhaps for future reference, the most significant effect is upon the over-all immunity and resistance patterns of individuals and population groups. The only data available suggest that general as well as specific resistance patterns may be influenced.

Finally then, what is a rational justification for antibiotic therapy in primary respiratory disease which the physician can use? After marshalling all of the evidence at his command—epidemiologic, clinical, and if possible laboratory—and insulated from patient and commercial pressure—the physician must let his clinical judgment tell him that *his patient,* not just his peace of mind, will benefit from therapy. He must feel that this is *the one* of perhaps 20 similar patients in whom antibiotic therapy will have a positive favorable effect on the outcome of the illness which outweighs all negative factors.

There is reason to suspect that if this basis of judgment were universal among physicians, the effect would be a sharp reduction in antibiotic consumption in this country.

Summary

A review of respiratory disease in children as it is now understood emphasizes four basic concepts. The first is that the clinical manifestations of acute respiratory disease are common to most known etiologic agents and render the majority of respiratory illnesses difficult to assign to agents on clinical grounds. The features of both bacterial and viral respiratory disease which support educated guessing are outlined. Second, most primary respiratory disease is nonbacterial in etiology. Third, bacterial complications of respiratory disease occur frequently in children and give the most frequent indications for specific treatment. The nature and etiologic agents involved in these complications are discussed. Lastly, there is the concept of the rare need for antibiotic therapy in primary respiratory disease and of the factors which may enter into the development of a physician's personal approach to therapy in this problem.

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The Biologic Foundation of Menstruation and Uterine Bleeding

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During the last quarter of a century the pace of investigative work on biologic aspects of menstruation has diminished. Presumably, this decrease reflects the view that rather complete information on the subject is available. Certainly fundamental characteristics of the menstrual cycle have been thoroughly investigated. The objective here is not to review the literature but to clarify the biological basis of menstruation.

The human, the anthropoid apes and old world monkeys all menstruate approximately once a month.[1] It is not a coincidence that these species which menstruate have the largest brains in relation to the size of their bodies. Certain primitive monkeys deriving from stock with smaller brains menstruate in microscopic amounts.[2, 3] Their menstrual cycle closely resembles the estrous cycle and represents a transition between the two.[4] The still smaller brained mammals ranking below the primates do not menstruate, and bleeding in their reproductive cycle does not correspond to menstruation in the primate.[5]

Large brains developed in the animals which evolved on land where there is an unlimited source of oxygen in the atmosphere to support respiration. Mammals with blood circulations adapted for transporting large quantities of oxygen support the largest brains. Their reproduction centers about internal incubation of a tiny egg almost completely devoid of yolk which is a limited source of oxygen and water. With very little stored nourishment the tiny mammalian zygote establishes intimate contact with uterine tissues for oxygen and metabolic transfer.[6] In smaller brained mammals simple apposition of egg membranes and endometrium is sufficient for respiratory and metabolic exchange.[7] These membranes peel from the endometrium at parturition without damage to maternal tissue.[7, 8]

In the ascending orders of mammals greater brain development in the internally incubated fetus follows an ever increasing surface contact between the egg and maternal tissues for sufficient respiratory exchange. Chorionic villi invade the endometrium and tear bits of it away at parturition. In larger brained mammals where considerable chorionic invasion occurs, protection of maternal tissues is provided by modifications of the endometrium.[9] It is superficially thickened with the thickened portion separated from its base by a spongy layer which confines the plane of detachment.[3]

In the deepest chorionic invasion for support of the primate's fetal nervous system, the ultimate source of tissue oxygen, the maternal blood stream, is reached. A blood circulation bathing villi of the invading trophoblast is supplied by a highly vascular endometrium. For preservation of the mother's life during parturition, the fetus and its membranes are developed completely within the detachable layer of the endometrium.[10] In addition to endometrial cleavage, protective functions at parturition necessarily include prompt occlusion of the rich arterial blood supply to the separating endometrial layer.

These conditions are extreme in the human. The invading chorion opens up the endometrial blood circulation about its villous processes in only a matter of hours after embedding, and the embryonic brain differentiates rapidly. At two months the brain comprises a large part of the embryo and maintains this structural superiority throughout its incubation.[11] For respiration, the chorionic villi develop an enormous surface area of contact with the maternal blood stream. Cleavage of the superficial endometrial layer containing the fetus and its membranes is produced simultaneously with occlusion of its copious blood supply. This prompt vascular occlusion, eliminating the blood supply to the compact and spongy layers of the endometrium, is the dominant feature

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of the reproductive cycle in menstruating primates.[12, 13] It is the basis of both menstruation and parturition. The uterus undergoes the same sequence of functions on a smaller scale during the menstrual cycle which it undergoes on a larger scale during pregnancy, labor, and the puerperium.[14] The menstrual cycle and the primate reproductive cycle are the same. In either case the uterus empties itself and closes off the blood supply to the inner superficial layer of the endometrium by the same method.

Whether a cycle ends in menstruation or delivery of an embryo or fetus depends upon the stage of development which the ovum has attained when the uterus empties. If the ovum develops just past the stage of embedding, emptying of the uterus is an abortion. If the ovum fails to reach the embedding stage, emptying of the uterus is by menstruation.[15] Control of the endometrial blood supply is paramount throughout the primate reproductive cycle because of the extreme endometrial vascularity from the very beginning of the cycle. Also, the fundamental protective function of the circulation, the blood-clotting mechanism, is abolished in the endometrial capillaries to permit the establishment of a microscopic blood circulation about the villi of the embedding egg particle. Dysfunctional uterine bleeding, abortion, premature separation of the placenta, and postpartum hemorrhage are all results of faulty uterine control of the endometrial blood supply in various stages of the human reproductive cycle.[14]

If the ovum dies after fertilization but before it embeds in the endometrium, the uterus empties itself in the succeeding menses. This theoretically fits the concept of abortion though from the practical standpoint only an unaltered menstrual period occurs.[15] In the human, systemic effects following fertilization take place only after the egg attacks the endometrium. If the ovum dies just after it has embedded when its chorionic gonadotrophins have briefly extended the life of the corpus luteum, the abortion can be clinically differentiated from an unaltered menstrual period. The onset of bleeding is slightly delayed, the cramps are more severe and prolonged, and clots may be passed. Endometrial scrapings in more advanced cases may show evidence of degenerating villi. If the fertilized ovum dies during contact with the endometrial epithelium, both the criteria for abortion and menstruation are fulfilled. It is in this case that any assumed difference between menstrual functions and abortion breaks down both from the theoretical standpoint and the practical standpoint. Evidence does not indicate that the moment the blastodermic vesicle erodes the first cellular membrane of the endometrium the uterus instantly changes to another organ of altogether different functions. Clinically, one can see that a pregnant woman having had regular menstrual periods does not abort between conception and the due date of the succeeding menses, because it takes that long for corpus luteum degeneration and labor to occur.

If the events of the menstrual cycle are scrutinized, one sees actually the processes of labor taking place in an empty uterus. Because the uterus does not contain the egg and its membranes, there is no division of labor into stages. The dominant vascular function occurs unobstructed by the presence of the developing ovum. The first change of labor that occurs in the uterus following degeneration of the corpus luteum is shrinkage of the entire organ from loss of fluid.[16] Uterine contractions present throughout the cycle continue, and at the point corresponding to the third labor stage, the uterus squeezes off the blood supply to the inner layer of the endometrium. The pain experienced at this time, that is, dysmenorrhea, corresponds to "after birth" pain following delivery at term. In each case the uterus carries out the same function on a different scale. Labor is not an exaggeration of uterine contractions but involution of uterine muscle fibers. Conversely, however, one sees that shrinkage of uterine musculature invariably produces a contracting organ.

In primates, which produce only one offspring in the reproductive cycle, preservation of the species hinges upon keeping the mother alive during reproduction. So important and dominant is the function of endometrial ischemia in the precarious reproductive cycle of the human that it is a constant and necessary danger to pregnancy itself. A faltering pregnancy must quickly give way to this function for prevention of exsanguinating hemorrhage. This endometrial ischemia function must be blocked soon after ovulation so that the ovum can embed with a constant blood supply. When the corpus luteum fails to develop, the menacing effect of the contracting uterus on the blood supply of the endometrium prohibits establishment of a microscopic circulation around the embedding ovum. Successive cycles without a corpus luteum provide no involution between cycles, and repeated growth stimuli produce the enlargement

of the uterus and endometrium which occurs in pregnancy. Withdrawal bleeding will tend to become continuous and profuse as the interval between cycles diminishes.[17] The important function between normal cycles in the primate is adequate involution within the musculature rather than changes within the endometrium. Within the endometrium the growth phase of the new cycle and the terminal ischemia of the old phase are superimposed. The returning blood supply of the new cycle is turned into retained tissues of the old cycle—conditions found in abortion.

Summary

Extreme vascularization of the endometrium during the human menstrual cycle provides the embedding ovum an immediate respiratory exchange to support the embryonic tissues. Control of this endometrial blood supply is the dominant feature of parturition. The uterus undergoes the same sequence of functions on a smaller scale during the menstrual cycle which it undergoes during pregnancy, labor, and the puerperium. Growth of uterine musculature accounts for a larger scale of uterine functions during labor. Labor, in turn, is involution of uterine musculature.

Between menstrual cycles growth of the uterine musculature must be balanced by sufficient involution to maintain constant uterine size. When involution between cycles is inadequate, the uterus enlarges and withdrawal bleeding tends to become continuous.

Since the uterus empties itself by menstruation when the ovum fails to embed, menstrual functions constitute an abortion. Thus, menstruation from the biologic standpoint is fundamentally pathologic and not normal.

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Volume XLVII
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Public Health and Its Relationship to Organized Medicine

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When I attempt to discuss this subject, I feel like the old man who was walking down the street one day and saw a boy sitting on the curb crying like his heart would break. Being a sympathetic old man and full of compassion, he walked up to the boy, put his arm around his shoulders and said, "What's the matter, young man; what are you crying about?" The boy looked up at the old man and said brokenly, "I'm crying because I can't do what I want to do." The old man sat down and cried with him.

As my entire experience has been in local level, rural public health, my remarks will be concerned with that phase of the subject.

The words health, public health, preventive medicine and organized medicine are widely used today by the laity as well as those in the professional field. I feel there is a great misunderstanding regarding the meaning of these terms and that consequently this is the partial cause of existing conflicts. I will attempt to define these terms before developing the subject and later will endeavor to develop the responsibility in each field.

"Health," as defined by the World Health Organization, "is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity."

Preventive medicine might be defined as the art and science of preventing disease, prolonging life and promoting physical and mental health and efficiency.

Public health is preventive medicine, but goes a step further in that it accomplishes the goals through organized community effort and action.

Organized medicine may be defined as the grouping of physicians in the county and state medical societies and the American Medical Association for the purpose of serving society.

Historical Review

In order better to understand the relationship of public health and organized medicine, I think it wise to review the background of both organizations including history, needs for being and accomplishments.

It has been stated that the purpose of organized medicine is to guide, educate and regulate the practice of medicine. Organization of the profession has resulted in the stimulation of effort, the establishment of standards both ethical and technical, and the study of social and economic problems as related to medicine and health. In further explanation it might be stated that the state society is a federation of county societies and the American Medical Association is a federation of the state societies. It has been said that the primary object of this association and the real reason for its coming into being in 1847 was the purpose of elevating the requirements for premedical education, raising the standard of medical education and the creation of independent boards of examiners for licensure. This would provide a high quality of medical service to the community and would prevent fraudulent medicine — quacks, charlatans, and schemers — from exploiting the public. The primary objective was accomplished although all medicine is still fighting to protect the public from quacks and schemers.

Organized medicine has an old and proud history which may explain its hesitancy and reluctance in accepting many social attitudes of the twentieth century.

The Assyrians and Babylonians are generally quoted as the first cultivators of medicine since the dawn of history, followed by the Egyptians and Greeks. At that time medicine was in the hands of priests and, although the sick were supposedly helped by the gods, the cult kept this knowledge in its own craft and was governed by a code of ethics. Thus, organized medicine, as it was, came into being several thousand years before Christ. The era of Hippocrates, however, and later of Galen, probably exerted the greatest lasting influence on medicine. In fact, the Oath of Hippocrates recorded about 2,400 years ago

Presidential address, read before the Florida Public Health Association, Tampa, Sept. 24, 1959

laid down the foundation of what has been called organized medicine.

Probably the first organization of medicine in this country took place in New Jersey in 1766. It is interesting to note that the Florida Medical Association was organized in Jacksonville in 1874.

Public Health, in contrast, is a rather young organization. In discussing its background, I am referring to official public health on a local, state and national level, although public heatlh in its true sense would include also all nonofficial and voluntary health organizations.

The earlier organizations were for the most part temporary boards of health set up to combat epidemics of disease. Organized medicine could really be called the "Daddy" as it recognized the need for more than individual action and instituted the development of these units. The physicians gave their services on a part time basis. As needs became recognized more clearly, permanent organizations were formed. Historically it is noted that the first local health department in the United States was formed in Petersburg, Virginia in 1780, and was followed by departments in New York, Baltimore and Boston. The one in Boston had as it first president Paul Revere. County organization as is most commonly known today came into the picture much later, and Jefferson County, Kentucky, has been generally accepted as having the first full time county health officer in 1908.

Public health on a local level in Florida began as local boards of health by authority of the legislature in 1881. Due to the lack of uniformity, however, and subsequent confusion during the epidemic of yellow fever in the state, they were abolished in 1893 with health authority transferred to the State Board of Health. It was not until 1931 that the legislature passed an enabling act authorizing the establishment of county health units. A rapid expansion followed, and there are now full time county and city health departments in 66 counties, offering health services to approximately 99 per cent of the population.

Most state health departments developed later than those in the cities. Although several states set up boards of health in the late 1800s, the earliest were the Louisiana State Board of Health, established in 1855, and the Massachusetts State Health Department founded in 1869.

The Florida State Board of Health came into being in 1889, in the wake of the disastrous yellow fever epidemic. Organized medicine in Florida first exhibited its cooperation and interest in public health in 1875 when the Florida Medical Association named a committee to study health boards of other states. The legislature was asked in 1876 to set up a State Board of Health and $1,500 was requested for that purpose. It was not accomplished until the later date. This spirit of interest, cooperation and assistance has continued throughout the intervening years at both state and county level.

There was a tremendous expansion of health activities both scientific and social in the early part of this century and with it the impetus for specialization. There developed a recognition for the need of health services on a local level, where the services could be adapted to local needs, resources and attitudes.

A survey by two outstanding leaders in the field of public health in 1945 gave a powerful stimulus to the development of local health services with full time health officers. This survey revealed that one third of the people lacked this coverage. They proposed that local areas of small population consolidate their services so that about 1,200 local health units could serve the entire United States. In 1955 there were about 1,500 full time local units serving about 71 per cent of the 3,067 counties but including more than 85 per cent of the population. In the Southern United States where county government is strong, good local health departments are much more prevalent. It is noteworthy at this point that Florida has gained national recognition in the field of public health. This honor could not have been accomplished without the initiative, cooperation, and full support of organized medicine in our state.

Similar to the American Medical Association, the American Public Health Association is the guiding light for workers in the field of public health. It was founded in 1872 and has been largely responsible for the growing up and development of the specialized field of medicine known as public health. Its primary objectives have been the development and improvement of standards of training and experience in the subspecialties field, selecting criteria for accreditation of graduate schools of Public Health and thereby eliminating inadequate schools, promoting objective types of examination for selection of candidates and upholding high standards of training for those who would enter our field. There are

48 affiliated societies of which the Florida Public Health Association is one. Unlike the American Medical Association which is composed of physicians only, public health is a worldwide program involving many disciplines including medicine, dentistry, pharmacy, nursing, engineering, statistics, education, laboratory science and administration. Consequently, there are 14 sections in the American Public Health Association.

Governments of all civilized countries have an official health service responsible for the health of the people. At the national level this frequently is called the ministry of health. I wish all public health workers and members of organized medicine could read the extremely interesting and enlightening report of Soviet Medicine and Public Health in a recent article in the American Journal of Public Health by Dr. Leona Baumgartner.

Excerpts noted with interest were: "All medicine in Russia is done by the government. . . . Ministry of Health provides the medical, dental, nursing, and related health services that the people get. There is no differentation in the USSR between public health and the rest of medicine; everything done in the field is spoken of as public health. . . . there is no voluntary health insurance."

This type of medicine is not for Americans and, with public health and organized medicine working cooperatively as an unselfish team for the good of the people, the described program of socialized medicine will never develop in this country. In contrast, we should briefly note that in the United States, health, welfare and education come under a single cabinet department at the federal level. The units which carry on major health programs are the Public Health Service, Children's Bureau, Food and Drug Administration, and Office of Vocational Rehabilitation.

Of vital interest to us, and one of the most distinguished, is the United States Public Health Service which was created by Congressional Act in 1798. Its initial purpose was for the relief of sick and disabled seamen, by Marine Hospital Service in principal ports. This was probably the first compulsory sickness insurance plan in the United States as 20 cents was deducted from seamen's pay each month for payment of services. This requirement was later changed.

Presently, the United States Public Health Service compiles national vital statistics, works with the federal agencies and represents the United States in international health activities. Its other activities in the United States are in three major fields—medical care, research and training, and services to the states by grants-in-aid and assignment of personnel to states. Loan of personnel to states is only by request of the respective state health officer, and a real point is made of not infringing on state's rights.

Public Health is now recognized as a specialty in the United States, with specialty boards for physicians and dentists working in the field. It is a specialty which requires postgraduate training, and such training is not within the province of a medical school. The day is rapidly passing when any physician without special training can qualify as a health officer or any nurse, engineer, or other member of the team, can get a full time job in a health department without additional training.

I have discussed the history and background of both organized medicine and public health for I believe they explain many of the earlier differences.

Converging Interests

I read an interesting article on this same subject, written by a rural practitioner of 35 years' experience. This paper was read before the first Pennsylvania Health Institute in 1941. If the date were unknown, one could believe it was written today. I would like to quote a few excerpts. "With the tremendous expansion of health activities along both scientific and social lines in the past fifty years has come the necessity for specialization. No longer can the family physician as such exercise all the functions of modern medical requirements. Quite naturally specialization brought about the birth of the many organizations devoted to the study and advancement of each special field. These organizations are all arms of the great complex of organized medicine today. Growth has, however, not been uniform nor symmetrical along all lines, so the organizational structure of medicine today presents a more or less grotesque figure of long arms and legs. The growth of the torso has not kept pace with the relative over-stimulated development of its parts. Organized medicine has come in for considerable unjust criticism because it, as the torso of the medical structure, has apparently not kept pace with the development of its right arm—public health. May it not be that the failure of co-ordinated growth was due largely to an under-

estimation of the part organized medicine could play in the advancement of public health?"

While the medical profession long ago recognized the necessity for the expansion of public health activities, it looked upon them as largely governmental function, not realizing that the field of public health should remain an integral part of the general field of medicine and not become an isolated offshoot. The profession may not have realized that the practicing physician should be an essential unit in all community health activities. Organized medicine was busy planning for postgraduate education of the practicing physician and other problems of individualized medical care. In the meantime, changing social and economic conditions, together with broadened concepts of public health needs, were expanding public health activities so that this field became no longer just a negative policing agency.

Whereas in the past, the field of public health and the practicing physician may have taken somewhat divergent courses, the time has come when these lines must converge, for our objectives are identical. Criticism, one of the other, will serve no useful purpose unless constructive, and offered for enlightenment. One of the major functions of specialized public health service is to make more effective the services of the practicing physician. Neither can be eliminated, nor can either be fully effective without the other. How does a community health program involve the practicing physician? A community health program is dependent for success upon an aroused community health consciousness, but I submit that the degree of this community consciousness is in direct proportion to the level of development of health consciousness in the individuals in that community.

All preventive measures finally resolve themselves into the welfare of the individual. The health of the community is a reflection of the health of the individual.

Converging of organized medicine and public health in a united front is rapidly approaching. Dr. Frank G. Slaughter has stated in addresses to organized medicine this past year, "The physician can no longer occupy an isolated place in the world and limit himself entirely to the day by day practice of his profession. Whether we wish it or like it, we as a profession are certainly going to have to play a much more integral role, not only in the care of diseased mankind but also in the field of public health, geriatrics, and medical sociology and economics. Perhaps the most deadly form of conformity as applied to doctors, is the widespread belief that a man of medicine must be isolated from the affairs of the world. Medicine must deal with the whole man in relationship to society, for man cannot long remain healthy in an unhealthy society."

Another physician also stated, "We are at times likely to overlook an important part of the patient—his family."

In cognizance of this philosophy, I am happy to note that the University of Florida College of Medicine has developed and instituted revolutionary changes in medical education. Its leaders have recognized the philosophy that a physician must also be a citizen, and that he must be prepared to accept responsibility for medical care of the families in his charge and ease not only the medical, but also the sociologic, psychologic and economic impact of disease upon the family. The physical plant at the University as well as the teaching is based on the same concept: better prepared physicians to meet the challenge of the future.

Dr. John D. Milton, in his presidential address to the Florida Medical Association a few years ago stressing the value of public relations to the patient and the public, said of the physician, "He must be a citizen as well as a physician, he must take part in civic activities."

The Florida Medical Association, a leader of organized medicine, has demonstrated for many years its expression of interest, cooperation, and good will toward official public health in its true meaning. A few examples noted of recent years are: Initiation of Indigent Cancer Program in cooperation with the State Board of Health; The Indigent Hospitalization Program in cooperation with the State Board of Health and Welfare Department; The Research Plan for Aid to Disabled; and the Citizens Medical Committee on Health. The Citizens Committee was appointed by the Governor on recommendation of the Florida Medical Association and prepared "A Study and Recommendation on Medical Care." As individuals, many leaders of Florida medicine have also allied themselves with public health as a coordinated team.

For many years now, outstanding men in the field of public health and organized medicine have realized and stressed the need of teamwork in the solution of our common problems. Although the American Medical Association has worked with the American Public Health Association for years

through committees. I, as a public health physician, was happy to note in Dr. Blasingame's address to the Eighty-Fifth Annual Meeting of the Florida Medical Association, "The American Medical Association has been reorganized—we need to act and function as an even more effective health team. We seek cohesion with the medical profession; we seek greater liaison and cooperation with all groups in the health picture." It is universally recognized that the practicing physician is the backbone of organized medicine and similarly, the local health department is the basic service unit in the administration of public health. It is usually true that strong health departments exist where local physicians exhibit interest and give support. Where physicians are disinterested or antagonistic, the health departments are usually weak or absent. It has also been demonstrated that *good* departments can remain progressive and alert to community needs or be blocked and frustrated, depending on the attitude of the physicians in the community.

Public health is, or should be, a great help to the physician. This is true where there is mutual understanding and cooperation. It is hard sometimes for nonmedical members of the public health team to realize the necessity of the local physician's cooperation and backing. The lack of understanding and overzealousness on the part of these workers may lead to more differences. I must admit that the fault often lies with the health officer. He may have failed to explain his objectives and the needs of the public to his fellow physicians. Too often he may, in his eagerness, move too fast, try to drag the people and the physicians with him rather than lead them. This approach may result from insufficient experience and training. The old expression that you can lead a mule to water but can't make him drink was never truer.

If all physicians and all health officers were members of their county medical society, many differences could be worked out by mutual understanding. Unfortunately, there are many instances when there is no society in the health officer's immediate county; thus, he must affiliate in another county. Needs and problems differ in each county, and often there is the justified feeling that the other county is not interested in him or his problems. Thus, through lack of a local organization, the health officer must develop a closer liaison with local physicians on an individual basis. There are times when the physicians do not get along with each other, but on the other hand, the health officer must get along with each of them.

Socialized medicine is one fear that unites physicians. Some of them apparently regard public health as an attempt by government to control the practice of medicine. Thus many health departments are restricted to minimal functions and in some instances are opposed in any programs other than communicable disease control and sanitation. Fear sometimes causes blindness, through lack of understanding. Public health is the strongest ally organized medicine has against socialized medicine. We could help more and would, were it not for the misunderstanding between a small number of physicians and health officers.

I have no formula for more closely uniting public health and organized medicine. I am happy and fortunate in the fact that throughout the past and present, I have had a wonderful relationship with my fellow physicians. I consider myself as a member of organized medicine and enjoy that personal relationship with each physician in my area. I consider them my friends and am confident that they consider me the same. We have mutual trust and respect and do not hesitate to go to each other with our problems. It is a fine feeling to know that health department services are utilized and appreciated by our physicians in private practice.

Public health is deeply concerned with the problems and frank inadequacies of our present day programs. In our planning we are concerned with the pressures of new and growing health problems, the increasing public health demands, the need for but lack of research, and the shortage of qualified personnel.

Closing Thoughts

Organized medicine and public health must, and I believe will, function as a team to meet the challenge of the future for the promotion of the health of our people. In these troubled times, I would like to repeat some simple rules for the maintenance of health and happiness based on the theory that it is easier to change our ways of life than those of mankind. These thoughts were taken from "Amid Masters of Twentieth Century Medicine" by Dr. Leonard G. Rowntree:

> "Observe the Ten Commandments and apply the the Golden Rule.
> Shake off the regrets for the past, the fears for tomorrow, and start to live happily for today.

Devote a day and night to perfecting plans for better living for yourself.

Define your objectives in life and live so as to attain them.
Cultivate courtesy at home and abroad, especially at home.
Cultivate tastes that are attainable, available, and satisfying.

When in doubt, seek guidance from the wise, and ask the Lord in prayer.
Learn to live for others—to give rather than seek.
Have and express opinions, but avoid useless and provoking arguments.
Cultivate companionship with your betters.
Try to make life one of interest, activities and zest."

In closing, I would like to quote a little prayer taken from American Medicine. I think it is as applicable now for guidance and relationships of public health workers and physicians in organized medicine as when given in closure by Dr. L. M. Anderson of Lake City, in his presidential address at the Fiftieth Annual Meeting of the Florida Medical Association in 1923:

Help me to learn; and find myself each day,
A little nearer to the truth, a little further on my way.
Let me be kind; and give me, too, the power to conquer self—
And all the doubts that rise from hour to hour.
Let me be strong; when problems try my soul
To see the right and do the right, with honesty my goal.
And when at last, my days draw to an end,
I ask no epitaph but this,
"He was a faithful friend."

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Spastic Ectropion

Report of Case

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Ectropion is usually divided into spastic, senile, paralytic, and cicatricial types. The spastic variety is generally described as an acute, temporary condition. It may occur in orbital inflammation and especially if there is proptosis and severe conjunctival swelling. It has also been described as occurring during examination of the eye of an infant with swollen eyelids and blepharospasm. If this latter type persists, the condition called paraphimosis palpebrae may result and require an anesthetic to reposition the lids. Snellen sutures have been proposed to replace the prolapsed conjunctiva.

Duke-Elder described the mechanism as essentially being opposite to that of entropion, and suggested that a firm, taut, and elastic skin with a resilient and preferably thickened conjunctiva in a prominent or proptosed eye would favor its occurrence. Since this type of skin is more likely to occur in the young, this condition is found more commonly in this age group. To my knowledge, spasm has not been considered to be a cause of a permanent ectropion.

The case here reported suggests that the cause might be a spasm of the orbicularis muscles, perhaps the result of a congenital defect in which the fibers were smooth instead of striate. Smooth muscle at orifices is usually in a state of tonic contraction. This then with a firm taut skin might produce pressure on the base of the tarsus instead of at the margin as in entropion, and thus produce an ectropion that becomes permanent. It is possible that the effect of puberty increased the tone of these muscles, thus causing the onset at that time.

Report of Case

A 28 year old white man was first seen on March 25, 1958 with bilateral ectropion since puberty or of about 15 years' duration. The eversion began first in the right eye, which has been more resistant to treatment. The only previous therapy was cautery punctures eight or 10 years before, all without effect.

The skin of the face and lids was taut, eliminating any possible idea of a flaccid etiology. Actually, the possibility of a cicatricial type of ectropion was considered because of the tight skin. No scarring was present, however, and there was no history of injury. The exposed tarsi were dry and scaly with much irritation.

Since not much information was available about such a case, a classical bilateral Kuhnt-Szymanowski operation was performed on April 3, 1958. Fifteen days postoperatively, there was undercorrection in the right eye, but the left eye showed a good result. In June and again in August, Ziegler cautery punctures were made in the outer half of the right lid without effect.

When the patient returned on December 2, there was a recurrence in both eyes. It was assumed that whatever had caused this condition in the beginning must still be present and the only plausible explanation must be spasm of the orbicularis muscle fibers. Thus on December 9 another Kuhnt-Szymanowski operation was performed, but this time all the orbicularis muscle tissue in the wound except that near the cilia was excised. It was noted at the operation on the right eye that the muscle bundle was larger and that the lateral tarsocanthal ligament was so weak and flaccid that the wedge in this layer was removed laterally and the tongue of the tarsus pulled into a notch in the lateral edge of the upper lid. This condition may account for some of the difficulty in obtaining as good a result in this eye. Pathologic study and recheck of this muscle resulted in a diagnosis of smooth muscle fibers.

Three weeks postoperatively it was evident that a good result had again been obtained in the left eye and that there was a slight undercorrection in the right eye. Examination on Feb. 22, 1960, approximately 15 months after the last operation, continued to show a good result in the left eye and a slight undercorrection in the right eye, and the patient was presumed cured. To date he has had no more ocular symptoms, and his whole personality has changed.

Summary

A case of chronic spastic bilateral ectropion in a youth is presented. Salient features are the onset at puberty, the requirement of muscle excision to effect a cure, and the pathologic report of smooth muscle. It might be reasoned that the effect of the further shortening of the lid margin in the second operation was the reason for the cure, but if I see another such case, I plan to excise the muscle at the first operation.

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Read before the Florida Society of Ophthalmology and Otolaryngology, Jacksonville, April 10, 1960.

Perforation of the Cecum by Prune Pits

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This report is prompted by the discovery of a perforation of the cecum in a senile patient caused by an accumulation of prune pits. It is surprising that such cases are not encountered more frequently; and it is my belief that this condition probably occurs more often than reports indicate, but escapes attention because of insufficient patient cooperation, information and symptoms.

Medical records are very scarce on the subject of perforations of the intestines by fruit pits. A search of the medical literature for the 10 year period between 1949 and 1959 revealed no article mentioning prune pits as the sole cause of perforation of the gastrointestinal tract. Occasionally, fruit pits have been mentioned as forming part of the composition of bezoars, which are themselves considered as medical curiosities because of their infrequency and bizarre nature.[1-3]

The Bezoars

The rarity, mysterious formation, and ancient and medieval mystical lore of the bezoars have attracted the attention of medical writers from time to time. The first recorded case of a bezoar was reported in 1779 by M. Baudamant of Paris, who found a hairball in a 16 year old boy at necropsy. Rudolph Matas[4,5] in 1914 reviewed 44 cases in which hairballs were present in the intestine. He mentioned that bezoar stones from goat's stomach were used for medicinal purposes by ancient Hindus 12 centuries before Christ.

An interesting and comprehensive paper was published in 1938 by De Bakey and Ochsner[6] on the subjects of bezoars in which they collected 311 cases. They stated that bezoars form an intensely fascinating and interesting study because of their infrequent occurrence, bizarre formation and mystical ancient legends of curative powers. An occasional hairball was noted as containing other fruit pits besides persimmon seeds.[7]

Crusaders returning from the Holy Land brought back a strange belief in the curative power of calculi found in the stomach of the bezoar goat of Persia. These stones were valued more than their weight in gold. Even Queen Elizabeth I had several bezoar stones incrusted in gold.

The bezoars are of two types, the phytobezoars (food balls with vegetables and fruit fibers) and trichobezoars (hairballs).[8,9] Phytobezoars caused by the green persimmon fruit were present in approximately 80 per cent of all cases reported.

Report of Case

A 72 year old white man was admitted to the hospital on March 31, 1954, with the complaints of nausea, vomiting, pain in the abdomen, and abdominal distention of 48 hours' duration. The patient complained of vague pain over the right lower quadrant. Subsequent to admission, he vomited a large amount of brownish watery material. There had been obstipation for the last 24 hours.

There was no history of loss of weight, hematemesis or melena, or gastrointestinal complaints. He had, however, experienced dyspnea on exertion. His mental condition had been diagnosed as cerebral arteriosclerosis without psychosis.

Physical examination disclosed a well developed and fairly well nourished white senile man, aged 72, who was acutely ill, toxic, and pale. He was fairly well oriented and could carry on a simple conversation. The temperature was 100 F., the pulse rate 90 per minute, the respiratory rate 24 per minute and the blood pressure 110/70 mm. Hg. His lips were parched, and his skin felt warm and dry. There was dyspnea on slight exertion, and mild pitting edema of the ankles. He was edentulous and without dentures. The examination of the heart showed no enlargement or murmurs, and the heart tones were soft. A few fine dry rales were heard over the bases of the lungs.

The abdomen was distended and tympanitic; the liver and spleen were not palpable. There was mild tenderness and some muscle resistance was present in the right lower quadrant. Rebound tenderness was absent; no masses were palpable. Peristalsis was soft and infrequent. Rectal examination was noncontributory.

Results of laboratory examinations were reported as erythrocytes 3,800,000 per cubic millimeter, hemoglobin level 11 Gm. per hundred milliliters, leukocytes 12,000 per cubic millimeter, polymorphonuclear leukocytes 75 per cent, urine specific gravity 1.015, and urine albumin, a trace. The blood chemistry value for nonprotein nitrogen was 50 mg. per hundred milliliters, for blood sugar 105 mg. per hundred milliliters, and for cholesterol 310 mg. per hundred milliliters. An electrocardiogram showed low amplitude of QRS waves in lead 1 and lead 2; depressed S-T's and flattened T's, and slurring of R-S; the impression was myocardial damage. Roentgenograms of the abdomen showed a stepladder pattern of dilated loops of small intestine, and several dense spots of undetermined nature in the region of the cecum. A barium enema revealed a filling defect in the cecum and several dense spots within the cecum of undetermined nature. A roentgenogram of the chest showed the heart slightly enlarged to the left, and haziness of the left costophrenic angle.

The patient was given supportive treatment. Intestinal decompression through a Levin tube was carried out. Intravenous treatment included 1 pint of citrated whole blood, glucose solution in normal saline and multivitamins.

A tentative diagnosis of carcinoma of the cecum with intestional obstruction was made.

On April 2, a laparotomy through a right lateral rectus incision was performed under spinal anesthesia. Peritoneal fluid was increased and blood-tinged. The serosa over the cecum and terminal ileum was inflamed and covered with fibrinous exudate.

The cecum was enlarged and felt like a bag filled with stones. There was a small perforation in the lower portion of the cecum about 1 inch lateral to a normal-looking appendix. The perforation was enlarged and a handful of prune pits was evacuated from the cecum. Further examination of the cecum, ascending colon and terminal ileum showed no induration, masses, or constriction.

The appendix was removed in the usual manner. The perforation was trimmed and closed by a double row of interrupted cotton sutures. Palpation of the remainder of the large and small intestines revealed no abnormality. The cecal area was irrigated with warm normal saline solution. A drain was placed in the cecal region coming out through a lateral stab wound. The laparotomy wound was closed in layers. The patient left the operating room in good condition.

The postoperative course was at first satisfactory. Bowel movements returned, and the abdomen became flaccid. On the seventh day, the patient suddenly became pale, weak and dyspneic. He was placed in an oxygen tent and expired 30 minutes later. The primary cause of death was given as arteriosclerotic heart disease with acute congestive heart failure.

Necropsy findings were as follows: "Mild Hypertrophy of Left Ventricle; Chronic Myocardial Degeneration and Fibrosis; Pleural Effusion; Acute Pulmonary Edema; and Arteriolar Nephrosclerosis. The abdominal peritoneum including the cecal area was found essentially negative. The cecal wound was well sealed with healing tissue. No lesion was found in the large or small intestine."

Anatomic and Physiological Factors

It is an amazing fact that a human can swallow unusual and bizarre foreign bodies and live to tell the tale. Foreign bodies found in the gastrointestinal tract have included various objects such as bezoars, nails, screws, pins, needles, glass and fruit pits.

The most frequent sites of the gastrointestinal tract which normally offer possible delay or obstruction to a foreign body are the pylorus, ileocecal junction, sigmoid, and rectum. Other less frequent sites are the pharynx, junction of the second and third part of the duodenum, the lumen of the appendix, the junction of the cecum and ascending colon, haustri, and flexures of the large intestine.

There is a natural protective tendency of the intestine to pass pointed objects with the point antiperistaltic and with the blunt end forward. Experiments on dogs have shown that gentle needle pricks on the intestinal mucosa produce anemia and shrinking of the spot, causing a small concavity at this point, and an actual increase in the diameter of the lumen, thereby facilitating propulsion of the foreign object. Normally a foreign body is propelled forward by the gastric and intestinal peristalsis.[1] In a comprehensive article Carp mentioned a patient with a stomach half filled with pins and hundreds of pins throughout the entire intestine. All the pins were passed in two and a half months without apparent ill effect.

Summary

Perforation of the cecum in a senile man, due to prune pits, is reported. Signs and symptoms mimicked carcinoma of the cecum. A search of medical literature between 1949 and 1959 revealed no articles on intestinal perforation caused by prune pits. This condition may occur more often than reported.

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Granulosa-Cell Tumor of the Ovary

Report of Case

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This presentation concerns a 25 year old mother of three children, the youngest only 14 months of age, who became ill on Feb. 3, 1957. Subsequently the diagnosis was granulosa-cell carcinoma of the ovary with metastases. Despite surgical and radiation therapy she died on June 27, approximately four and one-half months following the onset of the illness.

Report of Case

The patient first consulted me on March 4, 1957, at which time her chief complaints were nausea and vomiting of four weeks' duration. The onset of the illness began with normal menses on Feb. 3, 1957. Her local physician treated her with various injections, bed rest, and intravenous fluids. During this therapy she lost 10 pounds and complained of moderate pain in the lower abdominal region and constipation. The menstrual history revealed that since the birth of the 14 month old child the menses changed from a four week to a seven week cycle. The flow remained normal.

Positive physical findings at this first visit revealed a thin, chronically ill patient who weighed 105 pounds and presented a smooth pelvic tumor located in the left and posterior pelvic cavity, displacing the uterus anteriorly and to the right. The tumor was estimated to be 16 to 18 cm. in its greatest diameter. Laboratory studies at this time included a normal urinalysis, a hematocrit reading of 36, and a white blood cell count of 11,750 with a total polymorphonuclear count of 82, including 16 band cells. The Friedman test gave negative results, and a roentgenogram of the abdomen revealed a soft tissue pelvic tumor.

Five days later, a pelvic laparotomy was performed, at which operation a 16 cm. solid, smooth, bluish gray tumor of the right ovary was found. It was partially twisted on it pedicle and occupied the left and posterior pelvic cavity. A 4 cm. break in the surface of this tumor was noted on the superior surface, and adherent to it were a thrombus, the tip of the appendix, and a small portion of the omentum. There was approximately 50 cc. of dark bloody fluid in the cul-de-sac. Exploration of the entire abdomen failed to disclose any other pathologic change. A right salpingo-oophorectomy, an appendectomy, and resection of a portion of the omentum were accomplished. A frozen section analysis of the tumor was made, and the pathologist reported: "A solid ovarian tumor, probably granulosa-cell type. No apparent malignancy." The remaining ovary, although grossly normal, was bisected for further inspection. No pathologic change was noted, and it was closed.

The patient had an uneventful postoperative course. The final pathologic diagnosis received on the third postoperative day was granulosa-cell carcinoma of the ovary. Tumor cells were found in the thrombus attached to the appendix and the omentum, but there were no tumor cells within the tissues of these structures. There was markedly increased mitotic activity throughout the tumor cells. Most of the lymphatic vessels were greatly dilated and filled with tumor cells. On the fourth postoperative day a roentgenogram of the chest gave no evidence of metastatic disease.

In view of the patient's general physical condition and recent operative procedure, and following consultation with the roentgenologist, it was decided to treat the patient with deep x-ray therapy and follow this treatment with surgical extirpation of the remaining tube, ovary and uterus.

A series of outpatient deep x-ray therapy treatments followed. After the tenth treatment the patient felt poorly, complained of severe pelvic pain, had a temperature of 102 F. and also had physical findings of a left tube-ovarian mass about 6 to 8 cm. in diameter. The x-ray treatments were discontinued, and she was hospitalized on April 5, approximately one month following the initial operation, for treatment of left salpingo-oophoritis. Chloromycetin, Terramycin and Sigmamycin were used with equal futility. Surgical and medical consultations were obtained, and the conclusions were only speculative.

Subsequently, pain developed in the left lower portion of the chest, associated with a dry, hacking cough. Slight tenderness was detected in the left posterior popliteal space. She was treated with anticoagulant therapy in view of possible thromboembolic disease. The temperature returned to normal under this treatment, and she gradually improved. Diagnostic laboratory studies during this period of hospitalization included two roentgenograms of the chest, urinalysis, urine culture, two blood cultures, complete agglutination studies, and an electrocardiogram, all of which were within normal range. The complete blood count revealed a pronounced hypochromic anemia, which was corrected by blood transfusions. She was discharged on April 26, after a hospital stay of three weeks.

After anticoagulant therapy was administered for six weeks, the patient was readmitted to the hospital on June 8, at which time the anticoagulant therapy had been discontinued for 10 days. At the time of this admission a small fixed mass, approximately 4 to 6 cm. in size, was palpable in the cul-de-sac, and there was also a 6 to 8 cm. mass involving the left tube and ovary. She complained of a severe low backache and marked constipation.

A pelvic laparotomy was performed, and the findings revealed the descending colon and lower portion of the ascending colon to be covered with multiple miliary lesions. The omentum contained hard nodules varying in size from 0.5 to 3 cm.; the transverse colon and small intestine were grossly normal as were the liver and spleen. The sigmoid colon, left tube and ovary, posterior portion of the uterus, and cul-de-sac were all involved in a fixed, moderately firm mass. With considerable difficulty and constant oozing a total hysterectomy and left salpingo-oophorectomy were performed. The omentum was resected. During the operation 1,000 cc. of blood was required.

Microscopic study of the tissue, as reported by the pathologist, revealed metastatic granulosa-cell carcinoma of the fallopian tube, ovary, and tissue obtained from the left adnexal mass, as well as the omentum. The postoperative condition was poor until the third postoperative day, at which time she began to pursue a slow, gradual partial recovery. She was discharged from the hospital on June 22 and was flown to New York University Hospital at the request of her family. On June 27, two days following her arrival at this hospital, she had a convulsion, went into coma and died several hours later. Permission for an autopsy was not granted. Her attending physician in New York City thought that she probably had a cerebral metastasis.

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Delay in Diagnosis of Pulmonary Tuberculosis

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The majority of patients referred to the Southeast Florida Tuberculosis Hospital show evidence that tuberculosis had pre-existed for a considerable time before admission, 94 per cent being classified as having either far advanced or moderately advanced stages of the disease. For this reason a study to determine, if possible, the cause of the delay in recognition of the existence of pulmonary tuberculosis was deemed advisable.

The material in this study was obtained by personal interview with 200 patients, as well as by reviewing all available data during the summer of 1958. The patients studied were those who had been hospitalized for the first time and for less than one year. Ninety-two were white males, 28 white females, 52 Negro males, and 28 Negro females. Percentage-wise, this distribution is the same as that established in the hospital census on July 22, 1958. Forty-seven patients had histories of excessive alcohol consumption. One hundred and forty-seven had less than 11 years of formal education. Fifty patients had less than five years of formal education.

The relative frequency of the presenting symptom in this group of 200 patients was then determined. It will be noted from table 1 that a persistent cough was the first symptom in almost 50 per cent of the patients. Considerably less frequent as a presenting symptom were weakness, loss of weight, malaise, shortness of breath, pain in the chest, anorexia, epigastric distress and hemoptysis. Seventeen patients, or 8.5 per cent, were asymptomatic.

The time interval between the appearance of these symptoms and the patient's first contact with medical care was then determined. Any delay in this category could be attributed, therefore, to patient fault. Table 2 summarizes these findings. It is evident that patient delay in seeking medical care was an obvious fault in the great majority of patients. Only 44 patients, or 22.0 per cent, presented themselves promptly for medical care within the first month of their illness.

The role of the physician for possible delay in diagnosis was assessed by determining the interval between the patient's first presenting himself for medical care and the recognition of the disease. Table 3 summarizes the results of this analysis.

Although the figures in table 3 are indicative of a good score for physician diagnosis, the disease in 77 per cent having been diagnosed within one month of the time the patients presented themselves for examination, the extent of disease would tend to dilute the commendation the physician might otherwise deserve. One hundred and twenty-eight, or 64 per cent, were admitted in the far advanced stage of tuberculosis where the diagnosis would present little difficulty. Of the 80 Negro patients in the entire series, in 66, or 82.5 per cent, the disease was far advanced on admission.

Inasmuch as patient negligence in seeking medical care was such a large factor in the delay of diagnosis, only 44, or 22.0 per cent, presenting themselves within a month of the appearance of symptoms, a selected group of 131 patients was studied in the hope that they could supply some of the reasons for this delay. Table 4 lists their reasons according to frequency.

The largest number, 47, or 36 per cent of those questioned, were apathetic in regard to their illness. They failed to recognize symptoms of disease or illness. Twenty-seven, or 20.6 per cent, noted symptoms, but did nothing about them. An almost equal number, 26, or 20.0 per cent, misinterpreted the symptoms as of no consequence and due to the common cold. Nineteen, or 14.4 per cent, claimed that they did not have financial means to seek medical care. The fear of consequences of a diagnosis of pulmonary tuberculosis and failure to return for follow-up on their examinations were the causes in 12, or 9 per cent. In more than 100 of this group of 131 patients inter-

A Senior Medical Student 1958-1959 Project of the University of Miami School of Medicine conducted at the Southeast Florida Tuberculosis Hospital, Lantana, George Hames, M.D., Medical Director.

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viewed, a lack of proper information was obviously at fault in the delay of the patients to seek medical advice.

The 42 patients who went beyond a month before their illness was diagnosed by their physician were studied to determine the cause of the delay. In 39, some minor disease was suspected, and no further follow-up examinations were made. Thirty-three of these had no roentgen study of the chest. In two cases there was undue delay between the initial roentgenogram and its interpretation and report. In five instances the reasons for the delay could not be determined. Of a total of 200 patients, only five presented themselves for examination within a week of their complaints and had the diagnosis correctly made within that time. There were 17 patients who were asymptomatic and in whom the diagnosis of tuberculosis was made on a routine basis by roentgen examination of the chest and follow-up examinations.

Summary and Conclusions

Two hundred patients under treatment at the Southeast Florida Tuberculosis Hospital were studied in an effort to determine if there was a delay in the diagnosis of their disease and to determine, if possible, the cause for this delay. The findings indicated that there was a considerable delay in the majority of cases before treatment was initiated for the pulmonary disease. The major cause for this delay was patient fault in failing to recognize the presence of serious disease and failure of the patients to present themselves for medical care. Only 44 of the 200 patients sought such treatment within a month of the presenting symptoms. Tuberculosis had probably been present for at least two months or more, in view of the far advanced nature of the disease in the majority of the patients on their admission to the hospital. A lesser, but significant cause for delay in diagnosis was physician responsibility. There were 42 patients in the group who were under the care of physicians more than one month before it was recognized that they had pulmonary tuberculosis.

To reduce the delay in the recognition of the presence of this disease, it is apparent that the first need is education. The public must be informed that a persistent cough is not a minor or innocuous complaint, but the most frequent presenting initial symptom, and that any other symptoms affecting the general health are a distinct indication for seeking prompt medical advice.

Table 1. — First Symptom of Disease

Symptom	Number	Per Cent
Persistent cough	95	47.5
Weakness	24	12.0
Loss of weight	19	9.5
Malaise	13	6.5
Shortness of breath	10	5.0
Chest pain	6	3.0
Anorexia	6	3.0
Epigastric distress	2	1.0
Hemoptysis	1	0.5
Asymptematic	17	8.5
Other Symptoms	7	3.5

Table 2.—Duration of Symptoms Before Seeking Medical Care

	Number	Per Cent
1 year or more	18	9.0
5 to 12 months	34	17
1 to 6 months	104	52
Less than 1 month	44	22

Table 3. — Time Interval Between First Examination and Diagnosis

	Number	Per Cent
Diagnosed within one week	123	61.5
Diagnosed within one month	154	77.0
Diagnosed within three months	165	82.5
Diagnosis delayed beyond one month	46	23.0

Table 4. — Stated Reasons of 131 Patients Who Failed to Seek Medical Attention

Reason	Number	Per Cent
Failure to recognize the presence of illness	47	36.0
Disregard of symptoms	27	20.6
Misinterpretation (common cold, influenza, et cetera)	26	20.0
Economic	19	14.4
Fear of consequences	8	6.0
Failure of patient to return for re-examination	4	3.0

Likewise, the physician must be aware that pulmonary tuberculosis may be asymptomatic and that even the faintest suspicion of its presence requires close scrutiny and recognition by all means at hand, including roentgenograms of the chest, skin tests, examination of sputum and gastric contents, and any other measures he deems indicated.

Only by such an approach can one hope to see the patient early in the course of his illness, and his disease promptly and accurately diagnosed. Unless the seeds of tuberculosis can be contained before they are transplanted to healthy soil, its control and eventual eradication will be long-delayed.

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ABSTRACTS

Ureteral Antispasmodic Agents. Experiences with Atropine Tannate. By Miles W. Thomley, M.D., Louis M. Orr, M.D., James L. Campbell, M.D., and James B. Jamison III, M.D. J. A. M. A. 172:1634-1636 (April 9) 1960.

In this article the authors present the available evidence regarding the effectiveness of drug therapy on ureteral activity, particularly in the alleviation of renal colic. Findings are reported on the use of long-acting atropine tannate (Atratan) in 50 unselected cases of ureteral colic. The patients in this series were admitted to the hospital with a diagnosis of renal colic and were immediately given atropine tannate orally, receiving it every four hours thereafter. Thirty-nine of 40 patients with ureterolithiasis benefited from the atropine tannate. Thirty-five required no narcotics. Four required narcotics on one or two occasions. One of the 40 did not benefit from the drug. It is the authors' impression that the amount and frequency of narcotic required was markedly reduced by orally given atropine tannate. In 10 patients with no confirmation of ureterolithiasis there was no benefit.

It is concluded that on initial investigation orally given atropine tannate appears to be a valuable therapeutic agent in the treatment of ureteral colic. Side effects, while present, were not so objectionable as to preclude its use. These side effects, consisting of blurred vision, dizziness, and dryness of the mouth in four patients, did not interfere with ambulation and were less objectionable than those resulting from a full dose of narcotic. This preparation may be effectively used in the evaluation of the patient suspected of addiction. Therapy with this drug may allow patients with small ureteral calculi to remain at home comfortably in anticipation of spontaneous passage of the calculus.

Succinylcholine for Cesarean Section (A Preliminary Report). By Clifton Dance, Jr., M.D., and Richard Ward, Major, USAF (MC). Anesth. & Analg. 37:249-256 (Sept.-Oct.) 1958.

In the 63 cases comprising the series here reported cesarean section was performed with the use of Pentothal Sodium, succinylcholine and nitrous oxide–oxygen for anesthesia. In the opinion of the authors, this method fulfilled the three criteria essential to the perfect anesthesia for this operation. It did not perceptibly depress the fetus; it relaxed the patient and gave the surgeon adequate time in which to work; and it was safe and comfortable for the mother. They concluded that although a much more extensive clinical trial is desirable, the technique they describe is safe and comes close to fulfilling the requirements for a perfect anesthetic for cesarean section.

The Tables Turn. Presidential Address. By Charles J. Collins, M.D. Am. J. Obst. & Gynec. 78:697-705 (Oct.) 1959.

At the Twenty-First Annual Meeting of the South Atlantic Association of Obstetricians and Gynecologists, Dr. Collins presented for the entertainment and edification of the colleagues of his specialty a presidential address that might well be required reading for all physicians. This philosophical discourse deals not with the art and science of medicine but with the art of living that leads to the well balanced, abundant life. Dr. Collins speaks advisedly for his approach is unique. Motivated by the thought that members of his specialty, who advocate periodic examinations of women, might benefit by turning the tables and submitting to an examination by them, he sent a questionnaire to the wives of the members of the association and received 100 replies. Had they experienced resentment of their husband's profession, were the first or the latter years of marriage happier, what effect had the husband's profession had on him as a husband and as a father, had his professional knowledge of women made him a better husband, what main factors had made their marriage endure, had they received compensation in the happiness of their marriages for the sacrifices they had made, had the husband's home environment had any effect on his professional life, what were the sentiments of the widowed about the professional career of their deceased husbands, would the wives marry an obstetrician and gynecologist if they could repeat their life, and do they have an annual examination including a cytologic one—these were the questions.

Analysis of the questionnaire indicated that most of these busy specialists had good marriages. Among the reasons, one stood out like a beacon light—"the pride which our wives have in us and in our profession. . . . this sets our marriages apart from all others and is the main contribution to their success." With regard to the contributions of the husbands to their marriages, three facts stood out. Thirty-eight per cent of the wives had resented the husband's profession at some time, but the 70 per cent of this number who had overcome their resentments had done so alone by accepting an inevitable situation. Significantly, 43 per cent of the mothers considered their husbands inferior fathers. A third disturbing note was that at the time of life, after 30 to 40 years, when the marriages should be most rewarding, the factors that contribute to a happy marriage apparently were reversed to some degree.

For the well balanced life, Dr. Collins invites his colleagues to sit with him at an allegorical table in the banquet hall of Life and partake of work, family life, religion, adequate relaxation, hobbies, participation in civic activities, travel, literature, art, music—and for dessert? "It is our declining years when we can look back on the rewards and compensations of our life. It is the time when we can have that tremendously satisfying feeling of mission accomplished. I would admonish you to partake wisely of the multiple courses of this banquet so that your enjoyment of this *pièce de résistance* may not be impaired or your overindulgence prevent your presence."

Practical Notes on 'In Situ Carcinoma' of the Cervix. By Alvan G. Foraker, M.D. GP 21:89-92 (Jan.) 1960.

Specialization within specialization has reached the point where the physician may have difficulty in understanding the language and concepts of certain fields of medicine. There has, for example, been considerable confusion in terms used in describing activity of cervical epithelium from mild nonmalignant forms to invasive carcinoma. Since a knowledge of the semantics and current status of "in situ carcinoma" of the cervix has particular clinical importance to the majority of physicians, the author here offers a glossary of terms to aid in clarification for the practicing physician. In addition to giving clear, precise definitions for the various types of lesions, he explains the role of cytology and biopsy in this clinically important problem and summarizes the current status of "in situ carcinoma" with regard to present day diagnosis and treatment planning.

Pathogenesis of Coronary Artery Disease. By M. Jay Flipse, M.D. J. A. M. A. 172: 1130-1133 (March 12) 1960.

In this Chairman's address before the Section on Diseases of the Chest at the 108th Annual Meeting of the American Medical Association, Dr. Flipse outlines several modern concepts connected with the pathogenesis of coronary artery disease. Many aspects of this subject remain to be clarified, and particular interest centers on the metabolism of fats. He has studied the reactions of patients to different diets by standard chemical studies of total lipids, phospholipids, and cholesterol in the blood and also by a study of the particle-size of the lipoproteins of the blood. The results led to the conviction that the diet of patients with coronary artery disease should be designed to maintain the total blood lipid levels as well as the various fractions within normal limits. This objective is accomplished by limiting the daily intake of total fat to 50 Gm. and keeping the intake of saturated fats as low as possible.

In summary, on the basis of present knowledge Dr. Flipse listed five facts that can be accepted and applied. 1. Excessive body weight contributes to atherosclerosis and shortens life expectancy, particularly in males. 2. Eating excessive fat is not conducive to longevity. 3. Physical activity within capacity is helpful and beneficial in the maintenance of health, probably because of the effect in increased metabolism on carbohydrates and fats. 4. The sex differences in atherosclerosis have something to do with sex hormones. 5. Diabetes and hypertension speed up the process of atherosclerosis and increase the frequency of coronary and cerebrovascular accidents. Until the problem of atherosclerosis is completely solved, Dr. Flipse urges the medical profession to keep an open mind and await new discoveries. Meanwhile, he considers the present knowledge sufficient justification for careful control of dietary fats.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

PRESIDENT'S PAGE

A Tangled Web

O, what a tangled web we weave,
When first we practise to deceive!
—Sir Walter Scott

The phenomenal growth of health insurance, that is, the plan for partial or total prepayment of the cost of hospitalization and medical care, dates from the 1930's. Then, at the tag end of the depression, under the stimulus of physicians, Blue Cross came upon the scene to do that which many insurers said could not be done.

It has been done. It has created almost a new industry within the insurance industry. It is economically sound, but will remain so only as long as all parties to its use stay within the bounds of the terms of the various policies.

These parties are the insured, the vendors of medical care, and the insurance companies. The premiums which are paid for health insurance which permit the insuring companies to pay the claims against it and stay in business are based among other things on the anticipated use or needs as shown through actuarial experience within the confines of the policies. Policing of the claims is a part of the economic survival of the insurance companies. No bank could long stay in existence if it honored checks issued against nonexistent or overdrawn accounts. No men's clothing store could remain solvent if it included an extra pair of pants in the cost of a one-pair-of-pants suit.

Similarly, no health insurance company can pay claims for services not promised in its policies, or claims in excess of its liability, or claims padded beyond the usual fees for such services without going in the red.

As much as we physicians damn the interminable and sometimes complicated insurance claim forms, we still recognize that health insurance permits many of our patients to pay for our services, that insurance payments are a large segment of our income, that we would regret seeing such insurance disappear from the scene. The constant abuse of insurance by falsifying of claims in one form or another, the collusion between patient and doctor or between patient and hospital to collect for a service not promised or even excluded in the policy in question may very well be the undoing of the health insurance industry as it prices itself out of business in an attempt to provide in advance for anticipated demands above and beyond its liabilities.

Leo M. Wachtel

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JERE W. ANNIS, M.D.
JOHN M. PACKARD, M.D.
JOSEPH J. LOWENTHAL, M.D.

CARLOS P. LAMAR, M.D.
GEORGE T. HARRELL, M.D.
W. DEAN STEWARD, M.D.
WILSON T. SOWDER, M.D.
HAWLEY H. SEILER, M.D.
JAMES H. FERGUSON, M.D.

Doctors Don't Make House Calls!

This plaintive cry is heard on all sides by anguished patients who view this as prima facie evidence of the impersonal and callous attitude of the medical profession.

There is no doubt that doctors make *fewer* house calls than previously. Among the various reasons for this change is the availability of quick, safe transportation of the ill person to the office or hospital, where trained assistants and diagnostic facilities make treatment more accurate. The reasonable patient will appreciate these advantages if properly explained. In addition, the doctor is able to treat more patients in less time if he can remain in his office, but it is not as easy to explain that more persons are seeking medical care and that only by increasing the efficiency of the doctor and his team can they all be cared for properly.

Most doctors *do* make house calls, however, and perhaps this fact needs wider publication. Most doctors will make follow-up visits on a patient with a known illness or on those with crippling diseases which make transportation difficult except by ambulance, and most emergencies at night or on weekends are cared for in the home. The doctor often reaps intangible benefits from these visits, not only by improving the public's impression of the medical profession at the "grassroots" level, but by his improved understanding of the patient in his relations to other members of his family and by appreciating the environment in which the patient lives.

As in all other aspects of interpersonal relations, better communication will prevent misunderstanding and recrimination. The first office visit of a new patient is perhaps the best opportunity for the doctor to explain his own policy in the matter of house calls. At that time no emergency exists and hence the doctor can discuss his policies without upsetting a sick person or his distraught family. At a later time, the explanations are more difficult, but can be made by a properly trained receptionist or office nurse.

House calls *are* still made by the medical profession when it is to the mutual advantage of the patient and doctor. It is up to each of us to formulate his own policy and then to indoctrinate his patients, their families, and his own office staff, so that better understanding and eventually improved public relations will result.

Opinions expressed in editorials or commentaries, when signed or initialed, are those of the author and not necessarily of The Journal or the Florida Medical Association.

"Chronic Pulmonary Disease"

The term "chronic pulmonary disease" has long served as an easy escape from making an accurate pathologic and physiologic diagnosis. Until recently this lack of accuracy made little difference, for treatment was stereotyped, limited in scope, and of little avail. In the past decade, however, new techniques both in diagnosis and treatment have made it imperative that an accurate diagnosis be established in order to select the proper treatment from those now available.

This situation is not new to the medical profession, but it is often discouraging to find in 1961 that shotgun hematinics are still used when specific anemias can be so accurately classified, or to find children's disease diagnosed simply as "congenital heart disease" without an attempt to render definitive treatment based on appropriate laboratory studies.

Although many of the papers concerning pulmonary function studies are forbiddingly complex, yet the facilities for performing such studies are becoming widely available and reasonable in price. Properly performed and interpreted, they enable the physician to select for his patient the requisite treatment, which now encompasses surgery, antibiotics, steroids, positive or negative pressure breathing, oxygen or withholding oxygen, respirators, cardiac drugs, the enzymes, weight reduction, phlebotomy and many others. There is tremendous satisfaction in returning to useful life a patient who may appear moribund as a result of progressive pulmonary insufficiency.

An elegant paper by Ogilvie[1] epitomizes this brief essay. He studied a number of patients with chronic obstructive vesicular emphysema who had similar pulmonary function studies with the exception of the carbon monoxide diffusing capacity. In those patients in whom the emphysema developed after a long history of chronic bronchitis, the diffusing capacity was only slightly below normal and the prognosis was better than expected if severe infections and congestive complications were vigorously treated. In the second group, with marked impairment of diffusing capacity, there was rapid onset of dyspnea without preceding bronchitis. In these patients the prognosis was grave despite intensive treatment because the lung structure was affected.

With wider dissemination of the latest knowledge of pathologic pulmonary physiology and of the recent advances in therapy, the term "chronic pulmonary disease" will join "chronic myocarditis" as a vague and nondescript diagnosis which should be discarded.

J. M. P.

1. Ogilvie, C.: Patterns of Disturbed Lung Function in Patients with Chronic Obstructive Vesicular Emphysema, Thorax 14:113-121 (June) 1959.

1961 Annual Conference Presidents and Secretaries County Medical Socities

The Third Annual Conference for County Medical Society Presidents and Secretaries was held at the Hotel Robert Meyer in Jacksonville on January 14 and 15, 1961. Dr. Leo M. Wachtel, of Jacksonville, President of the Florida Medical Association, presided at the opening session on Saturday afternoon and explained the purpose of the meeting. Since its inception in 1959, this feature of the Association's program has been to strengthen the ties between the Association and its component county societies through this contact with their officers and to orient newly elected officers in the program of organized medicine at the state level. In arranging the annual gatherings, the Board of Governors also seeks to learn from the elected leaders the views, wishes and reactions of the members of the constituent societies. The success of the endeavor is attested by increased attendance and increased participation in the discussions each year.

Dr. Ernest B. Howard, of Chicago, Assistant Executive Vice President of the American Medical Association, discussed the current problems and programs of the parent organization, clearly elucidating the issues of the moment and the future outlook. He was followed by Dr. Jere W. Annis, of Lakeland, a recent president of the Association, whose topic was "Responsibilities of County Medical Societies." His threefold approach covered the officers' responsibility to the membership of the county society, the responsibility of the county society to the Florida Medical Association, and the responsibility of the county society to the community at large.

Emphasizing the responsibility of instilling into the individual members "their too-often-for-

gotten responsibility as citizens and as members of the nonmedical community," Dr. Annis said, "You have the responsibility of reminding your colleagues that they have a right—and indeed an obligation—to be interested in and informed upon current political issues, and that intellectual isolation in our professional life is neither admirable, exemplary, nor courageous. It is your job to remind us that we are members of a community—of a State—and of a Nation—as well as of a great and noble profession; and it is your job to help make us the unselfish, dedicated, ethical and intelligent individuals that we smugly believe ourselves to be. To do this, and to keep the respect—the friendship—and at times even the speaking acquaintance of your colleagues — is something of a task." His parting admonition was that within the next few years, organized medicine "will rise or fall—will continue or will virtually vanish from the face of the globe—as a direct result of the efforts of your County Society—and thousands like it—to fulfill these responsibilities to your membership—to your State organization —and to the public at large."

The remainder of the afternoon program was filled with four panel presentations followed by question and answer periods. The first panel dealt with "Florida Medical Association Programs." Dr. Marion W. Hester, chairman, of Lakeland, spoke on the Council on Medical Services; Dr. Thad Moseley, chairman, of Jacksonville, discussed the Scientific Council, and Dr. Homer L. Pearson Jr., chairman, of Miami, spoke on the Judicial Council. Under "Legislative Programs and Indigent Medical Care," Dr. H. Phillip Hampton, chairman, of Tampa, discussed the Council on Legislation and Public Agencies. He also spoke on the Committee on State Legislation, representing Dr. Edward R. Annis, chairman, of Miami, who was unable to be present. Dr. Wilson T. Sowder, State Health Officer, of Jacksonville, discussed Indigent Medical Care. Participants in the panel on "Florida Medical Association Investment Trust and Insurance Programs" were Dr.



Registering for the Conference are Drs. Duncan T. McEwan of Orlando; William A Mulford of Green Cove Springs; Samuel G. Hibbs, Kenneth G. Gould and Herbert B. Lott of Tampa (left to right).



Dr. Wachtel



Dr. Day



Dr. Harvard

Floyd K. Hurt, chairman, of Jacksonville, speaking for the Investment Trust Committee; Mr. James E. Devaney, of Jacksonville, representing the Pan American Life Insurance Company; and Mr. Edward A. Hightower, of Atlanta, representing Marsh and McLennan. The subject of the fourth panel presentation was "Fee Schedules—Blue Shield—Commercial Health Insurance." Dr. Robert E. Zellner, chairman, of Orlando, represented the Fee Schedules Committee; Dr. Russell B. Carson, president, of Fort Lauderdale, discussed Blue Shield; and Dr. Duncan T. McEwan, chairman, of Orlando, spoke for the Committee on Commercial Health Insurance.

Concluding the afternoon program, Dr. John D. Milton, president, of Miami, discussed the Florida Medical Foundation. He delineated the progress made by the Foundation and made an appeal for broader support of this worthy project.

Dr. S. Carnes Harvard, of Brooksville, President-Elect of the Association, presided at the session on Sunday morning. This meeting was devoted to the county medical society officers, who engaged in a profitable discussion of their respective programs and problems. The final feature of the two day meeting was a private broadcast at a nearby television station of the debate staged in New York the preceding evening on "Medical Care for the Aged" on N.B.C.'s The Nation's Future. Senator Hubert Humphrey, Democrat of Minnesota, represented the viewpoint of the incoming administration and Dr. Edward R. Annis, of Miami, represented the position of the American Medical Association.

The officers in attendance and the county societies they represented were:

ALACHUA: Dr. Raymond J. Fitzpatrick, Gainesville, president.

BAY: Dr. John J. Hollomon Jr., Panama City, president.

BREVARD: Dr. Frederick H. Lucas, Cocoa Beach, secretary.

BROWARD: Dr. Burns A. Dobbins Jr., Fort Lauderdale, president.

CLAY: Dr. William A. Mulford, Green Cove Springs, president; Dr. Joseph G. Ritch Jr., Orange Park, secretary.

DADE: Dr. Willard L. Fitzgerald, Miami, president; Dr. George W. Robertson III, Miami, secretary.

DUVAL: Dr. Sidney Stillman, Jacksonville, president; Dr. Robert J. Brown, Jacksonville, secretary.

HIGHLANDS: Dr. Samuel A. King, Avon park, president; Dr. Claude B. Henderson, Avon Park, secretary.

HILLSBOROUGH: Dr. Herbert B. Lott, Tampa, president; Dr. Samuel G. Hibbs, Tampa, president-elect.

JACKSON-CALHOUN: Dr. Terry Bird, Marianna, president.

LEON - GADSDEN - LIBERTY - WAKULLA-JEFFERSON: Dr. Nelson Kraeft, Tallahassee, president.

MANATEE: Dr. Warren G. Darty, Palmetto, president; Dr. C. Sumner Quimby, Bradenton, secretary.

MARION: Dr. Herbert M. Webb Jr., Ocala, president.

ORANGE: Dr. Norman F. Coulter, Orlando, president; Dr. Robert W. Curry, Orlando, president-elect.

PALM BEACH: Dr. William H. Proctor, West Palm Beach, president.

PASCO-HERNANDO-CITRUS: Dr. George R. Creekmore, Brooksville, president; Dr. W. Wardlaw Jones, Dade City, secretary.

PINELLAS: Dr. Walter H. Winchester, Dunedin, president.

POLK: Dr. John E. Daughtrey, Lakeland, president; Dr. Albert G. King Jr., Lakeland, secretary.

PUTNAM: Dr. Walter W. Weigel, Palatka, president; Dr. James R. Sayers, Palatka, secretary.

ST. LUCIE-OKEECHOBEE-MARTIN: Dr. Maltby F. Watkins, Fort Pierce, secretary.

SEMINOLE: Dr. Clyde F. B. Smith, Sanford, president; Dr. George H. Starke, Sanford, secretary.

VOLUSIA: Dr. C. Robert DeArmas, Daytona Beach, president; Dr. John J. Cheleden, Daytona Beach, president-elect; Dr. Thomas W. Ayres, Daytona Beach, secretary.



Dr. Howard



Representatives of twenty-two county medical societies gathered for the Conference.

Association Representatives

Dr. Leo Wachtel, Jacksonville, President; Dr. S. Carnes Harvard, Brooksville, President-Elect; Dr. Samuel M. Day, Jacksonville, Secretary-Treasurer; Dr. Ralph W. Jack, Miami, Dr. Joseph S. Stewart, Miami, Dr. Meredith Mallory, Orlando, Dr. John D. Milton, Miami, and Dr. Walter E. Murphree, Gainesville, members of the Board of Governors; Dr. Homer L. Pearson Jr., Miami, chairman, Judicial Council; Dr. Floyd K. Hurt, Jacksonville, chairman, Council on Medical Economics; Dr. Marion W. Hester, Lakeland, chairman, Council on Medical Services; Dr. Thad Moseley, Jacksonville, chairman, Scientific Council; Dr. T. Bert Fletcher Jr., Tallahassee, chairman, Council on Specialty Medicine; Drs. Ivan C. Schmidt, West Palm Beach, and Michael A. DiCosola, Sarasota, members, Council on Specialty Medicine; Dr. Robert E. Zellner, Orlando, chairman, Committee on Fee Schedules; Drs. Henry J. Babers Jr., Gainesville, Ralph S. Sappenfield, Miami, and Henry L. Harrell, Ocala, members, Committee on Fee Schedules; Dr. Duncan T. McEwan, Orlando, chairman, Committee on Commercial Health Insurance; Dr. John H. Terry, Jacksonville, member, Committee on Commercial Health Insurance; Dr. Charles Larsen, Lakeland, chairman, Committee on Industrial Medicine, and Dr. Edward Jelks, Jacksonville, Florida Medical Foundation.

Others Attending

Dr. Russell B. Carson, Fort Lauderdale; Drs. Thomas S. Edwards and Wilson T. Sowder, Jacksonville; Dr. Kenneth G. Gould, Tampa; Dr. Bertrand E. Lowenstein, Ocala; Dr. Ralph M. Overstreet, West Palm Beach; Mrs. John M. Butcher, Sarasota, president, and Mrs. W. Dean Steward, Orlando, president-elect, Womans Auxiliary to the Florida Medical Association; Dr. Ernest B. Howard, Chicago, assistant executive vice president, American Medical Association; Brig. Gen. Floyd L. Wergeland and Lt. Col. George L. Grow, Surgeon General's Office, Department of Army, Washington, D. C.; Dr. Paul V. Reinartz, Medical Director, Prudential Insurance Co., Newark, N. J.; Mr. H. A. Schroder, Jacksonville, Executive Director, Blue Shield, and Mr. Harry T. Gray, attorney for the Association.

Executive secretaries included Mrs. Mary K. Murray, Broward; Mr. M. John Hanni Jr., Dade; Mr. Marshall Brainard, Duval, and Mrs. Berneice Mathis, Orange.

Annual Midwinter Seminar Of Ophthalmology and Otolaryngology Held in Miami Beach

The Florida Midwinter Seminar of Ophthalmology and Otolaryngology held its fifteenth annual meeting at the Americana Hotel in Miami Beach during the week of January 29, 1961. The attendance from throughout the nation and especially from within the state was excellent with 384 registrants, 80 of whom were from Florida. The large number of states represented was also gratifying.

The program on the first three days of the week was devoted to Ophthalmology. Dr. Walter S. Atkinson of Watertown, N. Y., discussed local and general anesthesia as used in ocular surgery and numerous measures which offer excellent prophylaxis in cataract surgery. The subjects presented by Dr. William H. Havener of Columbus, Ohio, covered numerous traumatic lesions with special emphasis on hemorrhages into the eyeball and the new Zeissphoto coagulator and its use on the eyeball. Dr. Charles E. Iliff of Baltimore lectured on tumors of the eye and adnexa in children and on contact lenses, particularly their use in unusual ways. The present status of anti-infectious ocular therapy, and the therapy of uveitis and vascular disease of the eye were discussed by Dr. Irving H. Leopold of Philadelphia. Dr. Alfred E. Maumenee of Baltimore discussed lowering of intraocular pressure, various hemorrhagic lesions of the macula, and a new concept of conjunctival flaps across the cornea in lieu of the lamellar corneal graft in certain types of corneal infections.

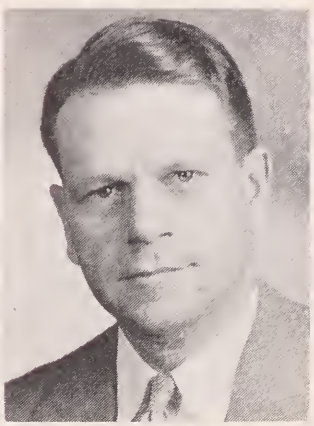
On the remaining three days of the week, the program of Otolaryngology began with a buffet breakfast featured by a question and answer panel entitled "Quiz the Experts." This innovation was received with enthusiasm. Lectures by Dr. John F. Daly of New York dealt with the management of cancer of the oral cavity, parotid swelling, and problems in managing the patient with a lump in the neck. Dr. David D. DeWeese of Portland, Ore., lectured on chronic rhinitis and sinusitis, management of vertigo, and facial nerve problems. Subjects presented by Dr. Paul H. Holinger of Chicago included the recognition of lower respiratory and esophageal anomalies and their management, the etiology of chronic laryngeal stenosis and its treatment, and bronchoscopic and esophagoscopic techniques. Dr. Harold F. Schuknecht of Detroit discussed exploratory tympanotomy, stapedectomy, and tympanoplasty.

Speakers Announced for Eighty-Seventh Annual Meeting May 25-28. Bal Harbour. Miami Beach



Dr. John Adriani of New Orleans, Professor of Surgery (Anesthesiology) Tulane University School of Medicine; Clinical Professor of Surgery and Pharmacology, Louisiana State University School of Medicine, and Director, Department of Anesthesiology, Charity Hospital of Louisiana at New Orleans. Guest of Florida Society of Anesthesiologists. Title of address: "Anesthesiology and the Hypertensive Patient."





Dr. Oscar Creech Jr. of New Orleans (left), William Henderson Professor of Surgery and Chairman of the Department of Surgery, Tulane University School of Medicine. Guest of Florida Chapter, American College of Surgeons. Title of address: "Present Role of Cancer Chemotherapy by Perfusion."

Dr. Charles A. Owen Jr. of Rochester, Minn., Head, Section of Biochemical Research, Mayo Clinic, and Professor of Medicine (Medical Research), Mayo Foundation, University of Minnesota Medical School. Guest of Florida Academy of General Practice. Title of address: "Diagnostic Radioisotopes."

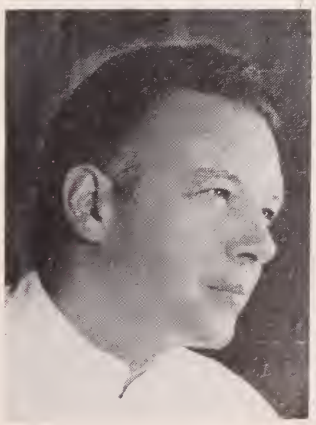


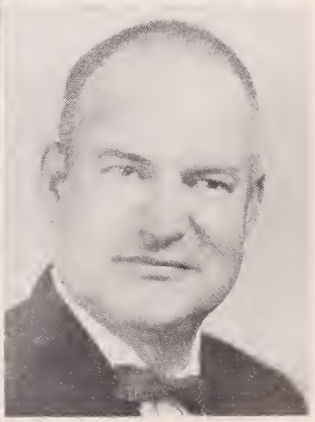


Dr. Harold W. Dargeon of New York (left), Chairman of the Department of Pediatrics, Memorial Hospital for Cancer and Allied Diseases, and Associate Professor of Clinical Pediatrics, Cornell University Medical College. Guest of Florida Pediatric Society. Title of address: "Chemotherapy in Juvenile Cancers."

Dr. Robert S. Hotchkiss of New York, Professor and Chairman of the Department of Urology, New York University, Bellevue Medical Center, and Visiting Surgeon in Charge, Fourth Surgery Division (Urology), Bellevue Hospital. Guest of Florida Urological Society. Title of address: "Unilateral Renal Disease and Its Role in Hypertension."

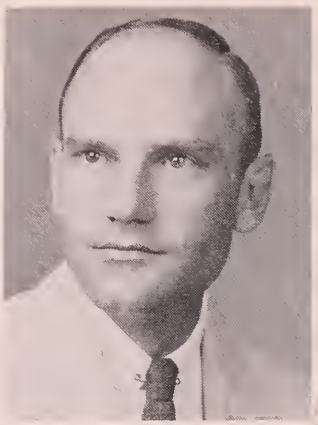
Florida Speakers





Dr. D. Ralph Millard Jr. of Miami (left). Title of address: "Immediate Reconstruction of Severe Soft Tissue Injuries."

Dr. Hilliard R. Reddick of Quincy. Title of address: "Visceral Larva Migrans."



Dr. George M. Stubbs of Jacksonville (left). Title of address: "A Review of Cholecystectomy."



Dr. Harry W. Reinstine Jr. of Jacksonville. Title of address: "Blood Volume Determination and Its Surgical Significance."



Dr. William H. Bernstein of Miami (left). Title of address: "Newer Methods for Detection of Congenital Cardiac Shunts."



Dr. Asher Marks of Miami. Title of address: "Clinical Use of a New Ventilatory Assistor."

Orange County Medical Society Resolution

There is published below a resolution by the Orange County Medical Society.

The Board of Governors of the Florida Medical Association and the Editorial Staff of The Journal regret that the editorial, "The Decline of American Medicine," which appeared in the October issue, was interpreted as casting particular or personal aspersions on the character or motives of any particular representative of this Association or of the American Medical Association; and they regret that a misunderstanding has resulted from the author's honest attempt to bring before the Association timely and cogent problems which seemed most important to him. Certainly, both the Board and the Editorial Staff of The Journal are appreciative of the leadership provided, both locally and nationally, by those individuals in our Association who have served faithfully and unselfishly during these recent years.

It is to be re-emphasized that the "Editorials and Commentaries" represent the opinion of the author and are not necessarily the convictions of the Florida Medical Association, the Board of Governors nor the Editor of The Journal. These articles appear by invitation and are the conscientious and thoughtful conviction of the author, representing his suggestions and opinions on matters of vital importance to the Association and its welfare. For the sake of clarity, this statement regarding these articles, which has always previously appeared elsewhere in The Journal, will hereafter be printed at the beginning of the editorial section. We hope that this will obviate any future misunderstanding.

J.W.A.

The Orange County resolution follows.

A RESOLUTION FROM ORANGE COUNTY MEDICAL SOCIETY

WHEREAS, the Journal of the Florida Medical Association is the official organ of the Florida Medical Association and the opinions expressed editorially therein are commonly accepted as reflecting the attitude of the Florida Medical Association, and

WHEREAS, there has emanated from the Board of Governors or the House of Delegates in recent years neither criticism of the officials of the American Medical Association in their handling of the grave problems which beset American medicine nor suggestions for other plans of action, and

WHEREAS, on page 418, of No. 4, Vol. 47 of the Journal of the Florida Medical Association dated October 1960, in paragraph 4 of an editorial entitled "The Decline of American Medicine" reference is made to "a recent AMA president" suggesting his "ineffectiveness" and indicating that "the fact that he challenged his adversaries to debates which never occurred did little to help our lot" and concluding that "at this time we need no silver-tongued high school debaters, but thinkers," and

WHEREAS, one of our colleagues has recently completed a term of office of the American Medical Association in which in the opinion of the members of the Orange County Medical Society he brought honor and distinction not only to the doctors of Florida and of the nation but to the office itself, and

WHEREAS, anyone reading this editorial and knowing that the most "recent American Medical Association President" is one of our colleagues and knowing of his vigorous espousal of the cause of American medicine and American doctors will conclude that these derogatory references are directed at him, and

WHEREAS, such references could hardly appear at a more inappropriate time and in a more inappropriate place than in the Journal of the Florida Medical Association, and constitute poor thanks from his colleagues to him for a job well done,

BE IT THEREFORE RESOLVED that (1) the Orange County Medical Society express its indignation to the Board of Governors of the Florida Medical Association and to the Editor of The Journal of the Florida Medical Association over the unkind, unwarranted, and untrue aspersions cast on our distinguished member, and (2) that The Journal print in an early issue an editorial disclaiming this editorial as expressing the view of the Florida Medical Association, and (3) the Board of Governors with the Editor of The Journal devise sme system of review of prospective editorials which will obviate the possibility of there appearing again in The Journal any editorial or other item which so clearly does not represent the thinking of the doctors of Florida.

Dr. Annis Speaks for Medicine On Television Debate Programs

On two recent occasions Dr. Edward R. Annis of Miami, representing the American Medical Association, has participated in debates before nationwide television audiences. On Jan. 14, 1961, he debated the question "Should Medical Care for the Aged Be Linked to Social Security?" with Sen. Hubert Humphrey (D., Minn.) on NBC-TV's program, "The Nation's Future." A few weeks later, on February 9, he met Walter Reuther, the president of the United Automobile Workers union, in a debate on the same subject of financing medical care for the aged through Social Security. This program on CBS television was the second in the new public affairs series "CBS Reports Presents Face the Nation."

Dr. Annis made the most of these two opportunities of rebutting proponents of Forand type legislation and ably represented the position of the American Medical Association before the vast audience. He pointed out that "the goal of all physicians in America and the American Medical Association is and always has been the provision of high quality medical care to the aged, regardless of their ability to pay," and explained that "physicians do *not* oppose help for the aged in meeting their health care, but we do feel that those who can afford to pay for their own medical care should do so, and that tax monies should be used to help only those who need help."

The distinguished Miami physician, who heads the American Medical Association's Speakers Bureau and is chairman of the Committee on State



Dr. Annis and Senator Humphrey



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sustains
retains

extra
antibiotic
activity

DEC

attains activity levels promptly

DECLOMYCIN Demethylchlortetracycline attains—usually within two hours—blood levels more than adequate to suppress susceptible pathogens—on daily dosages substantially lower than those required to elicit antibiotic activity of comparable intensity with other tetracyclines. The average, effective, adult daily dose of other tetracyclines is 1 Gm. With DECLOMYCIN, it is only 600 mg.

sustains activity levels evenly

DECLOMYCIN Demethylchlortetracycline sustai through the entire therapeutic course, the high ac ity levels needed to control the primary infection a to check secondary infection at the original—or another—site. This combined action is usually s tained without the pronounced hour-to-hour, dose dose, peak-and-valley fluctuations which char terize other tetracyclines.

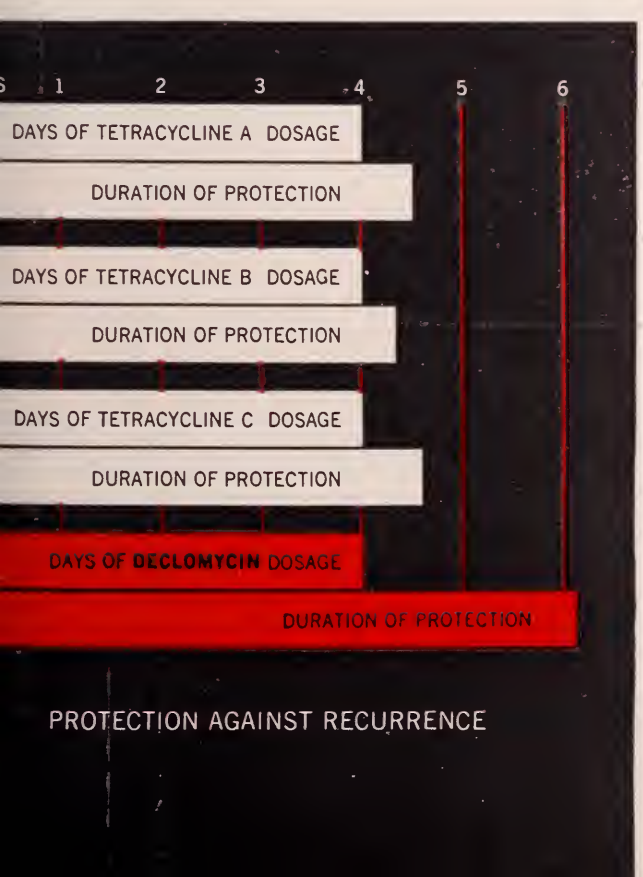


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CLOMYCIN Demethylchlortetracycline retains activity levels up to 48 hours after the last dose is given. At least a full, extra day of positive action may be confidently expected. The average, daily adult dosage for the average infection—1 capsule q.i.d.—is the same as with other tetracyclines...but **total** dosage is lower and duration of action is longer.



CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.

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Legislation of the Florida Medical Association, called medical care tied to Social Security "socialized medicine pure and simple for one segment of our population" and added that such a program "would eventually mean socialized medicine for everyone." To Senator Humphrey's denial that the use of the social security approach would be socialized medicine he retorted, "If anyone is qualified to define socialized medicine, it is the Socialist Party. And the Socialist Party calls this type of legislation socialized medicine." Commenting further, he said, "Socialized medicine is nothing but compulsory national health insurance. If we adopted it in this country, it would mean medicine controlled and administered by the Federal Government."

Speaking up for "a constructive alternative," Dr. Annis pointed out that the medical profession vigorously supported the Kerr-Mills Medical Aid for the Aged Law, passed by the Congress last September, and is helping to get this program under way. This law enables the individual states to guarantee to every aged American who needs help all the health care he requires, he said. Declaring it sound and effective, he urged that it "be given the chance it deserves."

Dr. Annis said that besides the cost "which would be astronomical in time," the social security approach "is totally unnecessary" now that the Kerr-Mills Law is in force. He added that social security taxes already are scheduled to reach 9 per cent of payroll in the years ahead. This approach in his opinion "would mean poorer, not better health care for the aged, and would lead to the decline, if not the end, of private health insurance, which has made such great strides in recent years." Discussing "flaws" in this approach, he said, "To begin with the social security approach is based on the theory that all of the aged are in poor health and distressed financial circumstances. This is not true. The majority of the elderly are in reasonably good health and reasonably good financial position. Survey after survey bears this out. Yet those who accept Senator Humphrey's position propose to help everyone eligible for these social security benefits, regardless of whether this help is needed or not."

Dr. Annis acquitted himself equally well in the debate with Mr. Reuther. The discussion was spirited, and at the conclusion of the allotted period the participants were requested to continue the debate at a later date on the same program.

Southeastern Dermatological Association Belleair, April 15-16, 1961

The 1961 meeting of the Southeastern Dermatological Association will be held at the Belleview Biltmore Hotel in Belleair on April 15 and 16. The scientific program includes case presentation at Morton Plant Hospital in Clearwater and a panel discussion with visiting dermatologists Dr. Arthur C. Curtis, Professor of Dermatology, University of Michigan Medical School, Dr. Leon Goldman, Professor of Dermatology, University of Cincinnati College of Medicine, and Dr. Pardo-Castello, former Professor of Dermatology, Havana, Cuba, participating. A number of Florida dermatologists will also take part in the program.

Dermatologists of the Tampa Bay area will serve as hosts. They include Drs. Morris Waisman, Wesley W. Wilson, Allen Smith, Paul Winder and Neal J. Phillips of Tampa, Thomas W. Cooper of Lakeland, Richard S. Flatt of Sarasota, Arthur Appleyard Jr., Bronson R. Alexander and Kenneth J. Weiler of St. Petersburg, and Carl Youngkin and Helen L. T. Dexter of Clearwater. Dr. Dexter is the secretary and treasurer of the association.

Central Florida Medical Meeting Orlando, March 10-11

The Seventh Annual Central Florida Medical Meeting, sponsored by the Orange County Medical Society, will be held at the Cherry Plaza Hotel in Orlando, March 10-11, 1961.

The program will feature a renal symposium with six outstanding speakers scheduled to lecture on the following subjects: Dr. John H. Moyer, Professor of Medicine and Chairman of the Department, Hahnemann Medical College, "Renal Hypertension;" Dr. George C. Morris Jr., Associate Professor of Surgery, Baylor University College of Medicine, "Renal Aneurysm," and "Renal Artery Stenosis;" Dr. William J. De Maria, Associate Professor of Pediatrics, Duke University School of Medicine, "Nephrosis" and "Acute Nephritis;" Dr. George H. Miller Jr., Professor of Urology, University of Florida College of Medicine, "Diagnostic Tools in Renal Disease" and "Renal Stones;" Dr. Warren R. Guild, Attending Physician, Department of Internal Medicine, Peter Bent Brigham Hospital and Harvard Medical School, "Indication for and Use of the

Artificial Kidney" and "Chronic Renal Failure;" Dr. Richard E. Wilson, Assistant Professor of Surgery, Peter Bent Brigham Hospital, "Tissue Transplants" and "Renal Stones."

Fireside Conferences with the guest speakers will open the scientific program, Friday, March 10, at 8 p.m. The program for Saturday includes addresses by the invited guests on specific phases of renal problems. Speakers from Orange County Medical Society will include Dr. Louis M. Orr, immediate past president of the American Medical Association, and Dr. Norman F. Coulter, president of the county society.

While the meeting is in session, entertainment will be provided for the ladies by the Woman's Auxiliary. A cocktail party and dinner for doctors and their wives on Saturday evening will conclude the meeting.

Dr. Robert B. Trumbo is chairman of the arrangements committee. Mrs. John Jowett is chairman of the Woman's Auxiliary committee. Information concerning the meeting may be obtained by contacting one of the chairmen or Mrs. Berneice T. Mathis, Executive Secretary, Orange County Medical Society, 104 East Gore Ave., Orlando.

Family Doctors Program Schedule American Academy of General Practice 1961 Scientific Assembly, April 17-20

Opening ceremonies of the American Academy of General Practice Annual Scientific Assembly will take place at 1 p.m., Monday, April 17, 1961, in the Auditorium and Convention Hall at Miami Beach. They include a call to order by Academy President John G. Walsh, Sacramento, Calif. An invocation and welcoming addresses will follow.

A panel on the economics of medicine opens this year's Assembly, which continues through April 20. Moderated by Academy Past President John S. DeTar, Milan, Mich., the session features Mr. Roger Fleming, American Farm Bureau; Dr. E. Vincent Askey, American Medical Association president; Mr. Walter Reuther, United Auto Workers head; Mr. Howard Hassard, California Blue Shield Plan, and Mr. R. Conrad Cooper, vice president of the United States Steel Corporation.

Tuesday's program begins with a discussion on "The So-Called 'Simple Hernia'" by Dr. J. A. Glassman, University of Miami School of Medicine. The second presentation, "Delayed Sequelae of Upper Gastrointestinal Surgery," features one of the nation's top teachers, Dr. Alton Ochsner, New Orleans. Following the morning recess, Drs. Bernard P. Harpole, Portland, Ore., Lenox D. Baker, Duke University School of Medicine, and R. Arnold Griswold, Louisville, Ky., will discuss the problems connected with trauma of the extremities.

In the afternoon, attention will turn to the area of gynecology and obstetrics. The first lecture under this heading will be "What to Do About Vaginitis," presented by Dr. William F. Guerriero, Dallas, Texas. The second speaker, Dr. Robert B. Greenblatt, Medical College of Georgia, will evaluate the role of new progestational agents in treating the female.

Bridging the gap between matters gynecologic and those pertaining directly to birth, Dr. Isadore Dyer, Tulane University School of Medicine, will present a lecture on "Adnexal Disease," followed by a talk on "Emergencies in the First Stage of Labor" by Dr. Denis Cavanagh, University of Miami School of Medicine. The last lecture of the day deals with the vital and timely subject of "Radiation and Pregnancy." Cmdr. Thomas B. Lebherz, USN, will review present opinion on sources and probable effect of radiation on pregnancy, with practical clinical interpretation.

Wednesday's program offers a wide subject range and outstanding speakers. Starting off the morning session is an authority in the field of endocrine therapy, Dr. Edward Rynearson of the Mayo Clinic. He will discuss "What Price Hormones." The second speaker will be Dr. Louis Krause, University of Maryland School of Medicine, who will emphasize the importance of physical diagnosis. "Effects of Exercise on Cardiacs" is the topic selected by Dr. Herman K. Hellerstein, Western Reserve University School of Medicine. He will outline the responses of cardiacs to work, exercise, training and emotional stresses. The final morning speaker, Dr. George T. Harrell, dean of the University of Florida College of Medicine, will discuss cellular changes of sodium and potassium in man.

Wednesday afternoon will be devoted to cancer and dermatology, and the opening lecture asks the logical question, "Can You Diagnose Cancer?" To present this subject, the Academy has chosen Dr. Emerson Day, Cornell Medical College. A second Cornell representative, Dr. David A. Karnofsky, will discuss "Nonsurgical Treatment of Cancer." An Academy past president, Dr.

Malcolm Phelps, El Reno, Okla., will speak on "Living with Cancer."

The closing Wednesday session will be devoted to dermatology, and the initial presentation will be "Dermatology in Your Office" by Dr. Leon Goldman, University of Cincinnati College of Medicine. Both Dr. Goldman's lecture and that of Dr. Richard D. Brasfield, New York City, will be made through the medium of Eidophor color television. Dr. Brasfield's talk deals with "Tumors of the Skin."

The first session of the final day's program features a discussion on "Common Ear Problems" by Dr. Lester A. Brown, Atlanta, Ga. Dr. Brown will point out the pros and cons of four of the most controversial subjects of everyday otologic topics—serous otitis media, the "collapsed" tube, vertigo and the "new" stapes operation. A past president of the American Otological Society, Dr. Frederick T. Hill, Waterville, Me., is the second Thursday speaker. His lecture is on "Surgery of the Nasopharynx."

A panel on "Adolescence: Its Perspectives and Problems" closes the 1961 Assembly program. Moderated by Dr. Goodrich C. Schauffler, Portland, Ore., the panel is composed of Dr. George A. Constant, Victoria, Texas, and Dr. Edward M. Litin, Mayo Clinic.

BLUE SHIELD

Medical Assistants' Meetings

Beginning early in March the Physicians Relations Department of Blue Shield is sponsoring a series of meetings throughout the state for the personnel who man doctors' offices, the medical assistants. At these meetings information is to be presented which will aid the assistants in determining the Blue Shield benefits to which subscribers are entitled. Each participating physician will be advised as to the time and place of the meeting in his area.

Similar meetings were held early in 1959, which proved helpful to those who attended. Since that time many changes have taken place. Existing contracts have been liberalized by extending emergency care to 72 hours and providing coverage for ill babies from birth. One year ago groups meeting certain requirements became eligible for Extended Benefits or Master Medical Endorsements. Just recently, upon approval of the Florida Medical Association, the new type "K" contract was made available to groups of five or more. This new contract has greater benefits and broader coverage than the "J" type contract, with moderate additional cost. It has a Schedule of Allowances based on the approved relative value schedule, with service benefit income limits set at $4,000 per year for a family contract, $3,000 for a one person contract.

On July 1, 1960, one of the most comprehensive programs in protection against the expenses of illness ever offered went into effect. This was the Federal Employee Health Benefits Plan in which Blue Shield, together with Blue Cross, is participating. Since some of Uncle Sam's employees do not remain in the employ of the government, it became necessary to develop a conversion contract for former federal employees which meets all of the requirements specified by the Civil Service Commission. Thus was born the type "H" contract, which is essentially identical to the type "K" contract in scope of benefits and has the same Schedule of Allowances.

A major attraction at these meetings will be the unveiling of a more streamlined reporting form for Blue Shield claims—an improved Doctor's Service Report which we believe will save time for the office staff and speed the processing of claims.

Due to the variety of contracts, each with its own Schedule of Allowances, it is more important than ever that the applicable schedule be consulted when completing Doctor's Service Reports. It is essential that the office staff be completely familiar with claim forms and all Schedules of Allowances.

OTHERS ARE SAYING

Editorial

Most non-tax supported medical schools are continuing to have difficult financial times. Inflation has forced many salaries to be raised in order to keep adequate personnel on the faculty. Most medical schools are engaged in large scale research work to maintain their prestige and this is rather costly, even though a good portion of it is supported by grants from pharmaceutical houses and through governmental grants.

Tuitions have more than doubled since many of us have attended medical school but, as we all know, tuition fees do not begin to cover the cost of educating an individual in medicine. I would



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imagine that private philanthropy, which has helped support many schools in the years past, is somewhat less due to the high income taxes. All of these things have managed to place the non-tax supported medical schools in a tight financial bind.

This problem is not only faced by medical schools but is faced by most all graduate schools. However, private industry in many cases has stepped in to help subsidize graduate schools in other fields. Our medical schools are faced with the continual sugar-coated pill cure for their problems by federal subsidization. So far they have remained opposed to this.

We can help in this problem by contributions to A.M.E.F. or by direct contribution to your medical school. If your medical school is tax supported you may wish to help others who have to depend on private funds for their needs. In some areas the pharmacists have made contributions to A.M.E.F. in the name of a doctor at Christmas time in place of an individual present to the doctor. In other areas, when one doctor wants to repay another for professional services to himself or his family, he has made a contribution to A.M.E.F. rather than sending a present. Much time and effort can be spent on selection of what is considered a proper present and this can be saved by substituting the gift to the A.M.E.F. and with much more lasting benefit.

Your school and many others need your help and we must come to their aid as the "private industry of medicine" is you, the practicing physician.

Richard L. Foster, M.D.
The Record
Broward County Medical Association
May 1959

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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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STATE NEWS ITEMS

Dr. Jere W. Annis of Lakeland has accepted an invitation to lecture on "Group Practice" to the members of the senior class of the University of Miami School of Medicine on March 9.

Dr. Sanford Cobb of Miami has been appointed Associate Professor of Anesthesiology at the University of Miami School of Medicine. He was formerly Assistant Professor.

The Crossroads Cancer Seminar presented biennially by the Florida Division of the American Cancer Society, the State Board of Health and the local county medical society will begin April 3 at 8:00 p.m. in Fort Walton Beach. The other Seminars will be presented April 4 at Quincy, April 5 at Palatka and April 6 at Lake City. The principal speaker will be Dr. J. D. Pigott, who is a graduate of the Northwestern University Medical School, Diplomat of the American Board of Surgery, and a Fellow of the American College of Surgery. He will discuss cytology and uterine cancer.

The Seminar in Neurology originally scheduled for March 16-18 at the University of Florida College of Medicine, Gainesville, has been rescheduled for September 28-30. The Seminar will be under the auspices of Dr. Richard P. Schmidt, Division of Neurology, Department of Medicine.

Dr. Hyman J. Roberts of West Palm Beach will participate in the program of the Southern Regional Meeting of the American College of Gastroenterology being held March 19 in Houston, Texas.

Dr. Paul A. Mori has been elected president of the North Florida Radiological Society and Dr. Charles H. Newell has been chosen as secretary. Both are from Jacksonville.

The 42nd Annual Session of the American College of Physicians has been scheduled for May 8-12 at the Americana Hotel at Miami Beach. Physicians planning to attend are requested to obtain hotel reservations as early as possible.

Dr. Thomas H. Bates of Lake City celebrated his 70th birthday January 29, and the city ex-



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tended to him its congratulations. Meanwhile Dr. Bates continued to attend to his practice as he had done for 47 years, the last 36 years in his office in the same building. In addition to his practice, Dr. Bates serves as a member of the Columbia County School Board and has been active in Scout work, Parent-Teacher Association, the Rotary Club and the Presbyterian church. He is a past president of the Columbia County Medical Society, a member of the Florida Medical Association, the American Medical Association, the Florida Academy of General Practice, the American Academy of General Practice, and is a senior fellow of the Southeastern Surgical Congress. He was graduated from the Tulane University School of Medicine in 1913.

The University of Florida College of Medicine has been awarded a grant of $62,000 to finance a five year study on the anatomy of the cerebellum by Dr. Donald Goodman, Associate Professor of Anatomy. The grant was made by the National Institute of Neurological Diseases and Blindness.

Dr. Louis S. Moore of Naples has been elected president of the Collier County Mental Health Association.

The Fifth Post-Graduate Course on Fractures and Other Trauma, sponsored by the Chicago Committee on Trauma of the American College of Surgeons, will be held April 19-22 at the John B. Murphy Memorial Auditorium in Chicago. Inquiries should be addressed to Dr. John J. Fahey, 1791 W. Howard Street, Chicago 26, Ill.

Dr. Ralph Jones Jr. of Miami has been invited to appear on the program of the annual session of the Texas Medical Association being held April 23-25 at Galveston.

The Second Annual Pulmonary Disease Seminar, sponsored by the Dade County Tuberculosis Association in cooperation with the Dade County Medical Association, the University of Miami School of Medicine and the Florida Tuberculosis Association, is scheduled for Sunday, April 16, at the Deauville Hotel, Miami Beach. The local committee in charge includes Dr. Jack Reiss, Coral Gables, Dr. Leon S. Eiseman, Hialeah, and Dr. Charles F. Tate Jr., Miami. Dr. Julius L. Wilson, Director of Medical Education for the National Tuberculosis Association, New York, and Dr. Herman J. Moersch, Director of Education and Research, American College of Chest

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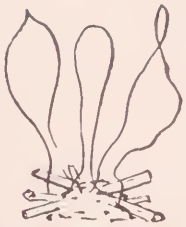
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Physicians, Chicago, will each moderate two panel presentations. Subjects of the panels include: "Pulmonary Tuberculosis;" "Chronic Superactive Disease of the Lung" and "Emphysema and Carcinoma of the Lungs." The Seminar has been approved for credit in Category I.

The Eleventh Annual Postgraduate Seminar of the Mount Sinai Hospital of Greater Miami has been scheduled for May 18-20 in the Seville Hotel, Miami Beach. The faculty, announced by Dr. Mortimer D. Abrashkin of Miami Beach, includes: Drs. Harvey Blank and Ralph Jones Jr., University of Miami School of Medicine; Gerson R. Biskind, San Francisco; Henry L. Bockus, Philadelphia; William Dameshek, Boston; Leon Ginzburg, New York; Arthur L. Haskins and Mark M. Ravitch, Baltimore; Demetrio Sodi-Pallares, Mexico City, and Jerome S. Harris, Durham, N. C.

Variety Children's Hospital of Miami has announced that the annual Arthur H. Weiland Lectureship will be presented at the Hospital April 3 at 8:00 p.m. The speaker will be Dr. James B. Arey, Professor of Pediatric Pathology, Temple University School of Medicine and St. Christopher's Hospital for Children. Dr. Arey is an outstanding pediatric pathologist whose major investigative work has been in the fields of pathology of the newborn and tumors of children.

New officers of the Jacksonville Dermatological Society were installed at the regular monthly meeting January 31. These included Dr. William C. Croom Jr., president; Dr. Jack H. Bowen, secretary-treasurer, and Dr. James R. Trimble, recorder. Guest speaker for the evening was Dr. David Welton, Charlotte, N. C., who read a paper entitled "The Clinical Application of Biostatistics in Dermatology."

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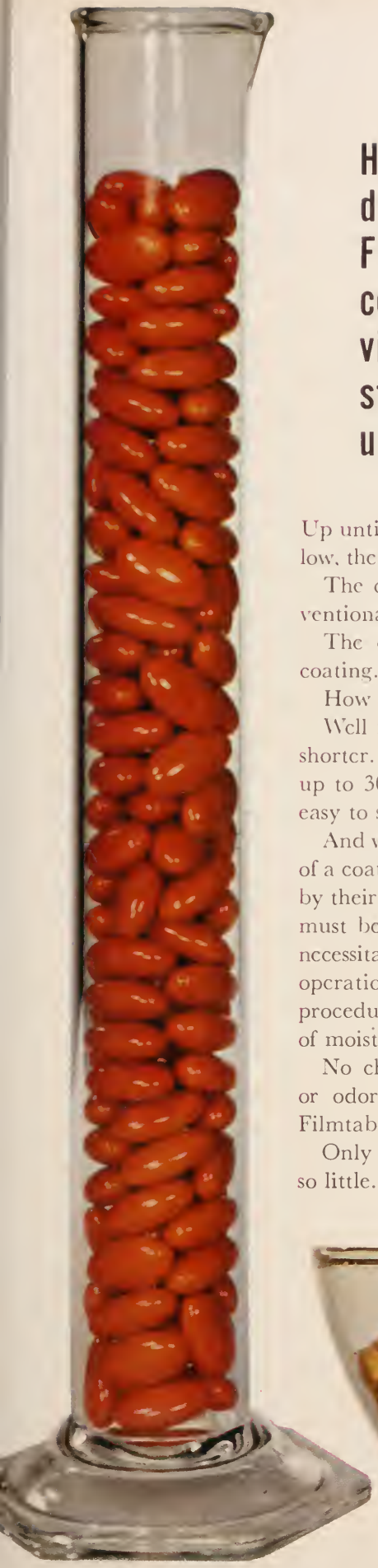
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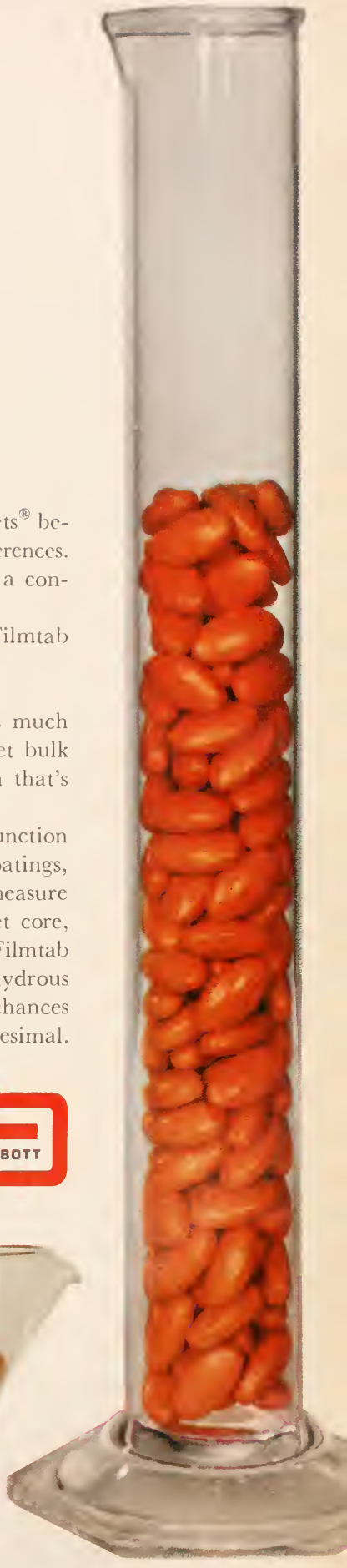
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In the path of any purposeful effort, there are obstacles that must be expected and overcome. For example, Blue Shield and the doctors who support it have not been without their share of problems in planning a program for care of the aged. Yet there has been no thought of giving up, for much has already been accomplished. As one doctor sums it up: "Blue Shield Plans already cover people over 65 in the same proportion as they exist in the population at large – and membership is growing at a faster rate in this age group!"

BLUE SHIELD®

The program guided by doctors

®Service marks reg. by Blue Shield Medical Care Plans

IL COUPON
or write to:
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Shield of Florida, Inc.
Riverside Avenue
cksonville, Florida

Please send me samples of available Blue Shield literature which I may distribute to my patients. ☐
Please have a Blue Shield physician relations man visit me in my office ☐ yes; ☐ no.

Name _____, M. D.

Address _____

City _____



NICOZOL®

ORIGINAL FORMULA

The ideal cerebral tonic and stimulant for the aged.

NICOZOL therapy (the original formula) affords prompt relief of apathy. Patients generally look better, feel better; become more cooperative, cheerful and easier to manage.
No dangerous side effects.

NICOZOL contains pentylenetetrazol and nicotinic acid

For relief of agitation and hostility: NICOZOL with reserpine Tablets

Supply: Capsules • Elixir

REFER TO PDR
see page 581

DRUG Specialties INC.

Write for professional sample and literature.

WINSTON-SALEM 1, NORTH CAROLINA



for the patient who is

coughing his head off

in upper respiratory infections

HASACODE®

- ✻ **Quiets the overactive cough reflex**
- ✻ **Relieves aches and fever**
- ✻ **Sedates the anxious patient**
- ✻ **Handy tablet form**

COMPOSITION: Each tablet contains:

Acetylsalicylic Acid	2½ grains
Acetophenetidin (Phenacetin)	2½ grains
Phenobarbital	¼ grain
Codeine Phosphate	¼ grain
Hyoscyamus Alkaloids	.0337 mg.

DOSE: One or two tablets every 3 or 4 hours, as required. Not more than 8 tablets should be taken in 24 hours. WARNING: *may be habit forming.*

also HASACODE "STRONG"

Same formula as HASACODE, but with ½ grain codeine phosphate. For use where relief of pain is the primary target. DOSE: As for HASACODE.

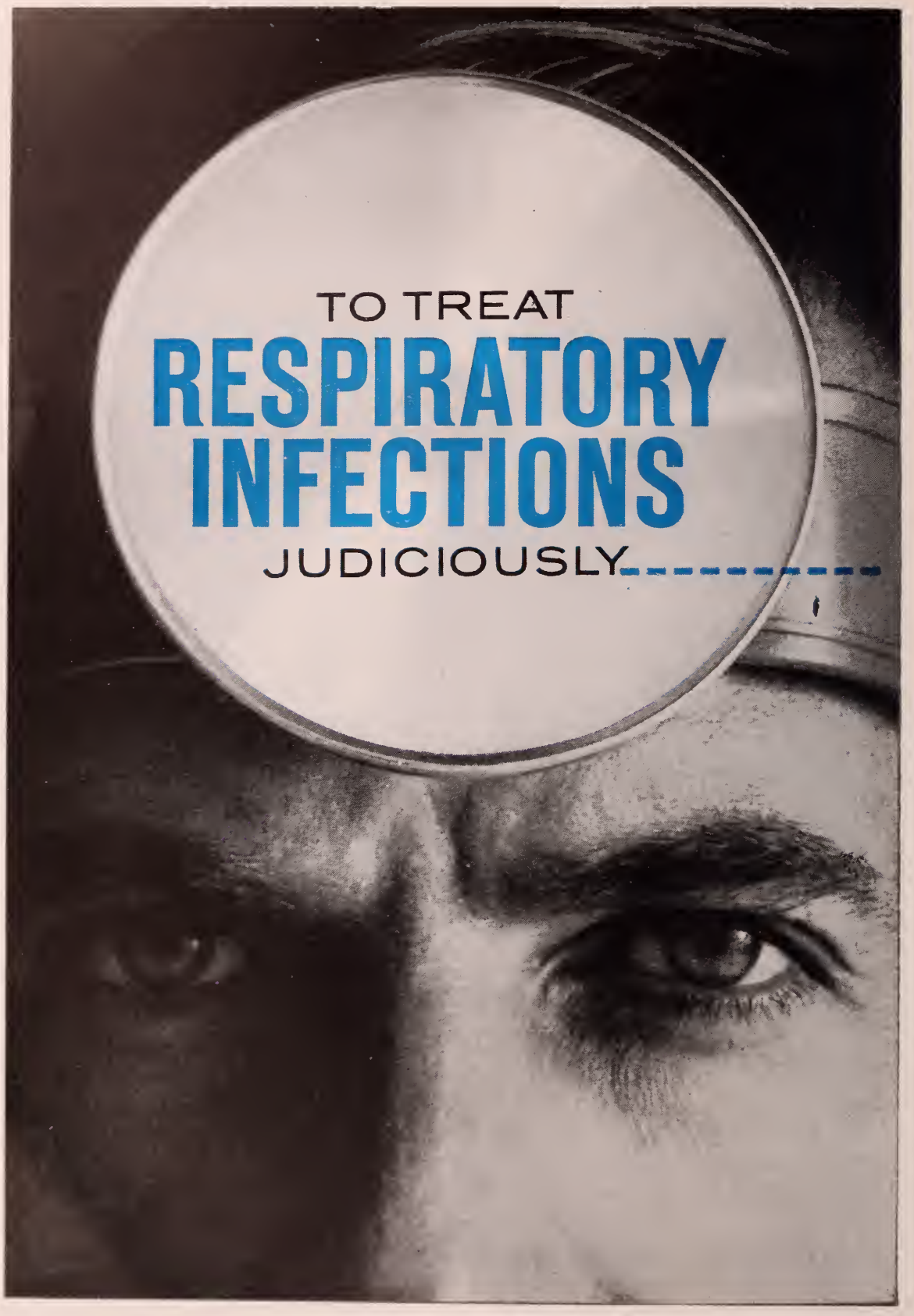
And for relief of less severe type of respiratory infection:

HASAMAL®

Same formula as HASACODE, but without codeine phosphate. DOSE: As for HASACODE.

SUPPLIED: All forms available in bottles of 100 and 500 tablets.

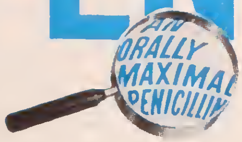
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Richmond, Virginia


TO TREAT
RESPIRATORY
INFECTIONS
JUDICIOUSLY

When it's penicillin-susceptible
and the patient is not allergic
Use an orally maximal penicillin

MAXIPEN®

potassium phenethicillin



Consistent dependable therapeutic response through maximal absorption, maximal serum concentration and longer duration of inhibitory antibiotic levels for less susceptible organisms.

Available as Maxipen Tablets, 125 mg. and 250 mg.; Maxipen for Oral Solution, 125 mg. per 5 cc. of reconstituted liquid.

Literature on request

— or —

When you hesitate to use penicillin
(eg. possible bacterial resistance or allergic patient)

You can count on

TAO®

triacetyloleandomycin

Extends the Gram-positive spectrum of usefulness to include many staphylococci resistant to one or more of the commonly used antibiotics—*narrows* the spectrum of side effects by avoiding many allergic reactions and changes in intestinal bacterial balance.

Available as Tao Capsules, 250 and 125 mg.; Tao Oral Suspension, 125 mg. per 5 cc.; Tao Pediatric Drops, 100 mg. per cc. of reconstituted liquid; Intramuscular or Intravenous as oleandomycin phosphate. Other Tao formulations also available: Tao®-AC (Tao, analgesic, antihistaminic compound) Tablets; Taomid® (Tao with Triple Sulfas) Tablets, Oral Suspension.

Literature on request

and for nutritional support **VITERRA®** vitamins and minerals
Formulated from Pfizer's line of fine pharmaceutical products

New York 17, N. Y., Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

"...extraordinarily effective diuretic..."[1]

Efficacy and expanding clinical use are making Naturetin the diuretic of choice in edema and hypertension. It maintains a favorable urinary sodium-potassium excretion ratio, retains a balanced electrolyte pattern, and causes a relatively small increase in the urinary pH.[2] More patent than other diuretics, Naturetin usually provides 18-hour diuretic action with just a single 5 mg. tablet per day — economical, once-a-day dosage for the patient. Naturetin c̄ K — for added protection in those special conditions predisposing to hypokalemia and for patients on long-term therapy.

Supplied: Naturetin Tablets, 5 mg., scored, and 2.5 mg. Naturetin c̄ K (5 c̄ 500) Tablets, capsule-shaped, containing 5 mg. benzydroflumethiazide and 500 mg. potassium chloride. Naturetin c̄ K (2.5 c̄ 500) Tablets, capsule-shaped, containing 2.5 mg. benzydroflumethiazide and 500 mg. potassium chloride. For complete information consult package circular or write Professional Service Dept., Squibb, 745 Fifth Avenue, New York 22, N. Y.

References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 2. Ford, R. V.: Current Therap. Res. 2:92 (Mar.) 1960.

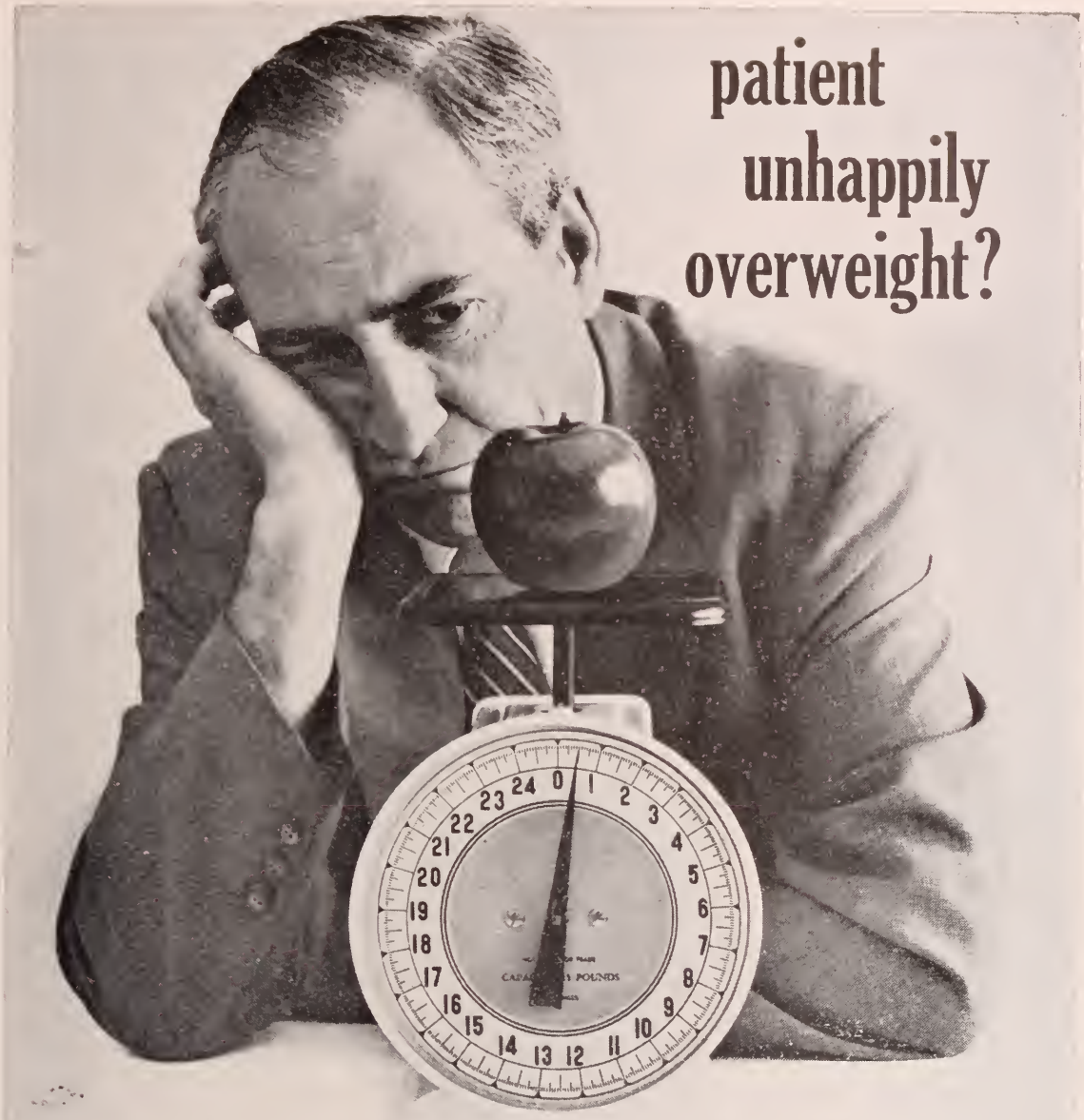
Naturetin Squibb Benzydroflumethiazide

Naturetin c̄ K Squibb Benzydroflumethiazide with Potassium Chloride

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brand Methamphetamine Hydrochloride

Controls food craving, keeps the reducer happy—In obesity, "our drug of choice has been methedrine . . . because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent."[1] Literature available on request.

Supplied: Tablets 5 mg., scored. Bottles of 100 and 1000.

[1] Douglas, H. S.: West. J. Surg. 59:238 (May) 1951.

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In over five years

Proven
in more than 750 published clinical studies

Effective
for relief of anxiety and tension

Outstandingly Safe

1. simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
2. no cumulative effects, thus no need for difficult dosage readjustments
3. does not produce ataxia, change in appetite or libido
4. does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
5. does not impair mental efficiency or normal behavior

Miltown®

meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.
Also as MEPROTABS®—400 mg. *unmarked*, coated tablets; and as MEPROSPAN®—400 mg. and 200 mg. *continuous release* capsules.

• WALLACE LABORATORIES / *Cranbury, N. J.*

CM-2597

®TRADE-MARK

of clinical use...



...for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a ***known*** drug. Its few side effects have been fully reported. ***There are no surprises in store for either the patient or the physician.***

NEW analgesic

Kills pain



stops tension

For neuralgias, dysmenorrhea, upper respiratory distress, postsurgical conditions... new compound kills pain, stops tension, reduces fever—gives more complete relief than other analgesics.

Soma Compound is an entirely new, totally different analgesic combination that contains three drugs. First, Soma: a new type of analgesic that has proved to be highly effective in relieving both pain and tension.* Second, phenacetin: a "standard" analgesic and antipyretic. Third, caffeine: a safe, mild stimulant for elevation of mood. As a result, the patient gets more complete relief than he does with other analgesics.

Soma Compound is nonnarcotic and nonaddicting. It reduces pain perception without impairing the natural defense reflexes.*

NEW NONNARCOTIC ANALGESIC

soma® Compound

Composition: Soma (carisoprodol), 200 mg.; phenacetin, 160 mg.; caffeine, 32 mg.
Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 apricot-colored, scored tablets.

NEW FOR MORE SEVERE PAIN

soma® Compound + codeine

BOOSTS THE EFFECTIVENESS OF CODEINE: Soma Compound boosts the effectiveness of codeine. Therefore, only ¼ grain of codeine phosphate is supplied to relieve the more severe pain that usually requires ½ grain.

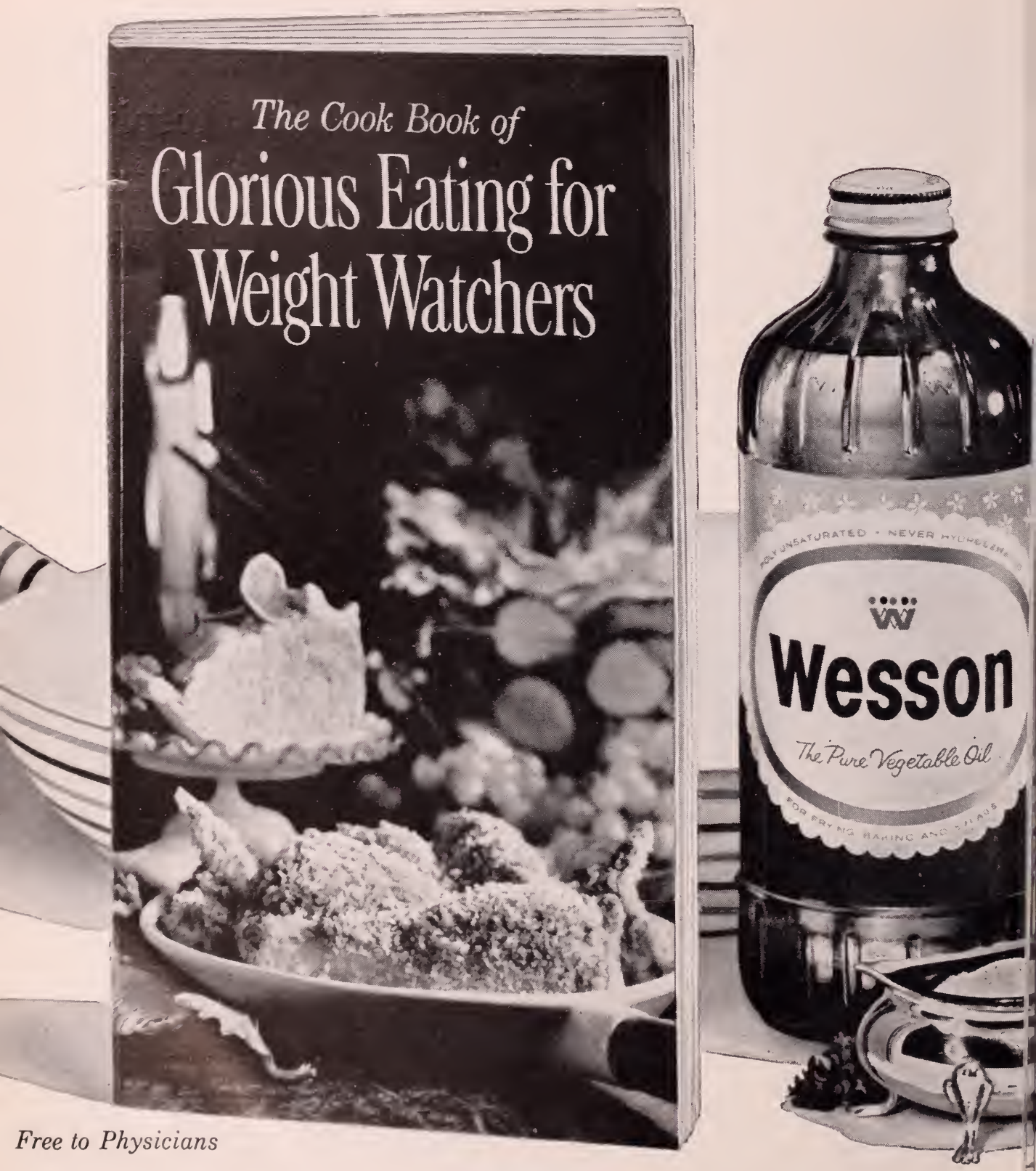
Composition: Same as Soma Compound plus ¼ grain codeine phosphate.
Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 white, lozenge-shaped tablets; subject to Federal Narcotics Regulations.

References available on request.

WALLACE LABORATORIES • Cranbury, N. J.

A REALISTIC AID TO PROPER WEIGHT MAINTENANCE

At Last...New Cook Book Designe



Free to Physicians

Menus fulfill the recommended dietary allowances of the Food & Nutrition Board of the National Research Coun

Prevent Overweight Through Better Eating Habits

Recipes and Menus that Provide Satiety and Appetite Appeal

The Cook Book of Glorious Eating for Weight Watchers fills the long-felt need for a weight control plan that is workable for everybody in the family. Realistic regimens are built around good, natural, readily-available foods enhanced by delicious methods of preparation. In place of "fad diets" or tasteless formulas, it provides for truly appetizing meals. It teaches and encourages the development of the healthful eating habits that can prevent overweight, America's #1 Health Problem. This full-color Cook Book contains 100 pages—248 delicious recipes each with calorie counts. Complete menus are here at 3 calorie levels—1200, 1800, 2600. Calorie levels are related to "best" weights by sex, age, size and extent of activity.

Many diets fail because they are "crash" programs only temporary in effect. Other diets are unbearable because they are monotonous and tasteless.

The Wesson way offers calorie controlled menus that emphasize appetite appeal, variety and satisfaction. They fulfill the recommended dietary allowances of the Food & Nutrition Board of the National Research Council.

All menus provide the proper amount of protein, carbohydrates, fat and the other essential nutrients. The principles of good nutrition are included to help the homemaker plan her own properly balanced, calorie controlled menus. With simple subtractions or additions to the same basic menu, each family member can be served delicious satisfying menus according to his individual needs.

Advance copies for physicians. "The Cook Book of Glorious Eating for Weight Watchers" has not yet been released to the general public. If you would like an advance copy for yourself, together with forms to enable patients to obtain their own *free* copies, please fill in coupon below.



Poly-unsaturated Wesson is unsurpassed by any readily available brand where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen. As an aid to physicians, Wesson has made available "Your Cholesterol Depressant Diet Book". This book is for professional distribution only—not offered *to laymen.*

Please do not confuse that offer with this one. "The Cook Book of Glorious Eating for Weight Watchers" *will be offered to the general public. It should be explained that this is not a reducing manual. Rather, it marks the first time that a major food manufacturer has taken so important a step in the interest of* prevention of obesity. *Therefore, it is expected that this new book will be highly useful to physicians in their practice.*

The Wesson People, Dept. M,
210 Baronne St., New Orleans 12, La.

Please send me my free advance copy of "The Cook Book of Glorious Eating for Weight Watchers."

Two dozen order blanks will be included for distribution to my patients who will receive free copies in return for 1 Wesson label. More blanks will be sent me if requested.

_____ M.D.

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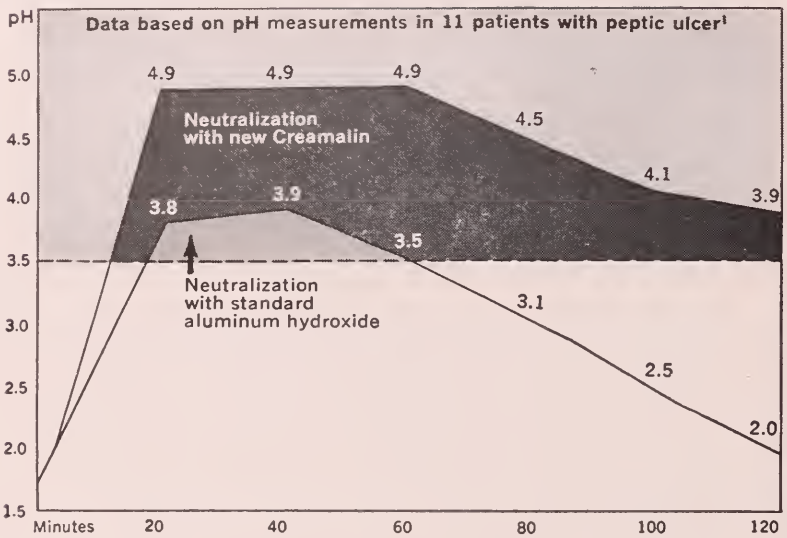
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(CITY, ZONE, STATE)

Poly-unsaturated **Wesson,** *the Pure Vegetable Oil, is Never Hydrogenated.*

At the site of peptic ulcer



Following determination of basal secretion, intragastric pH was continuously determined by means of frequent readings over a two-hour period.



neutralization is much faster and twice as long with

New CREAMALIN® ANTACID TABLETS

New proof in vivo[1] of the much greater efficacy of new Creamalin tablets over standard aluminum hydroxide has now been obtained. Results of comparative tests on patients with peptic ulcer, measured by an intragastric pH electrode, show that new Creamalin neutralizes acid from 40 to 65 per cent faster than the standard preparation. This neutralization (pH 3.5 or above) is maintained for approximately one hour longer.

New Creamalin provides virtually the same effects as a liquid antacid[2] with the convenience of a tablet.

Nonconstipating and pleasant-tasting, new Creamalin antacid tablets will not produce "acid rebound" or alkalosis.

Each new **Creamalin antacid tablet** contains 320 mg. of specially processed, highly reactive, short polymer dried aluminum hydroxide gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles of the powder offer a vastly increased surface area for quicker and more complete acid neutralization.

Dosage: Gastric hyperacidity — from 2 to 4 tablets as necessary. Peptic ulcer or gastritis — from 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed whole with water or milk, or allowed to dissolve in the mouth. **How supplied:** Bottles of 50, 100, 200 and 1000.

1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

Winthrop LABORATORIES
New York 18, N. Y.

for peptic ulcer ■ gastritis ■ gastric hyperacidity

1467M

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Active

Basinger, James W., Dade City
Capmany, Fernando, Miami
Celano, Eugene R., Fort Walton Beach
Dobert, Philip, Key West
Drawdy, Robert E., Plant City
Escamilla, Jorge O., Brooksville
Feintuch, Henry, Miami Beach
Fowler, William O., Orlando
Galitz, Philip J., Perrine
Genest, Aloria H., Miami
Grisinger, George F. Jr., Miami
Jackson, Royce V., Madison
Klein, Melvin, Coral Gables
Knowles, Henry A. M., Crestview
Lauth, Edward J. Jr., Miami
Leavitt, Philip, North Miami
Lustig, Julian, Miami Beach
Martinez, Hubert G., Miami Springs
McGinty, James J., St. Petersburg
Mixson, Charles A., Milton
Mummery, Charles R., Miami
Rachlin, Bernard, Miami
Salzman, Stanley H., Miami
Sidwell, Walter F., Milton
Smith, Arthur G., Dunedin
Stander, William H., Miami Beach
Surgnier, Richard V., Brooksville
Sutton, Elbert W., Milton
Tanner, Charles L., Kendall
Toth, Alexander G. Jr., Coral Gables
Whitehurst, James R., Bowling Green

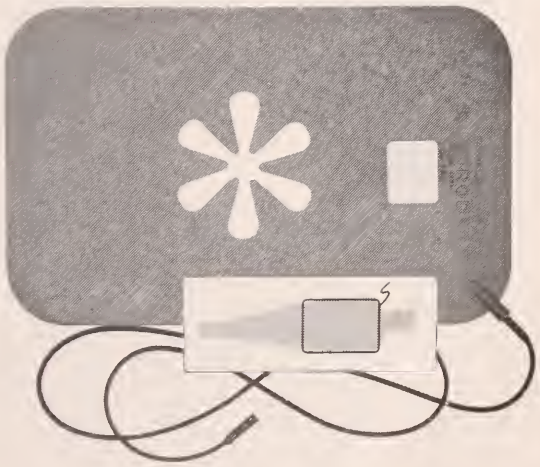
Associate

Alecce, Paul M., Miami
Alexander, Gerald L., Miami Beach
Applebaum, Richard M., Miami
Barish, Landis, West Palm Beach
Brown, Marjorie E. T., Miami
Bunim, Louis A., Miami Beach
Carroll, William J., Orlando
Cohen, Arthur N., Opa Locka
Cox, Jerry F., Delray Beach
Earnhart, William R., Delray Beach
Harris, Joseph, Miami Beach
Irish, Louise, Boca Raton
Kuhn, Mark A. R., Fort Lauderdale
Lessner, Howard E., Miami
Lewis, Alfred L. Jr., Tallahassee

* THE NEW BIRTCHER SAFETRODE

NOW . . . make burns by indifferent electrode during electrosurgery an impassibility. The Birtcher Safetrade is a large, flat candenser (25½" x 15½", molded in autoclavable neoprene) that matches the capacity of the patient's body and induces energy into the patient. It completely eliminates the antiquated metal indifferent plate which nurse and doctor must continually check far proper fit and contact —no need for messy jellies either. Simply place the Birtcher Safetrode on the operating table in a position approximating the trunk of the body with the usual sterile sheet draped over it. Safetrode daes not depend on skin contact for proper functianing. Patient may be moved at will, in any position, with no reasan far cancern. Thoroughly tested and enthusiastically approved by surgical staffs of leading hospitals. Fits every make and model af electrosurgery machine. Specify make and model when ordering so praper card tip can be fitted. Order a Birtcher Safetrode far every electrosurgical unit now. STOP BURNS . . . STOP LAWSUITS!

ELIMINATE INDIFFERENT PLATE BURNS * IN ELECTROSURGERY!



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Margulies, Charles, Miami Beach
Markarian, Berge H., Hialeah
Markiewicz, Stanley S., Coral Gables
Matlin, Jordon S., Miami
Reiss, Jack, Coral Gables
Shilen, Thomas S., Miami
Weybright, Dorthea M., West Palm Beach

BIRTHS AND DEATHS

Births

Dr. and Mrs. Walter R. Lambert of Miami announce the birth of a son, Albert Thomas, on December 21, 1960.

Dr. and Mrs. James B. Strachan of Jacksonville announce the birth of a daughter, Suzanne, on December 19, 1960.

Dr. and Mrs. Paul A. Tanner Jr. of Auburndale announce the birth of a daughter, Mary Elizabeth, on December 25, 1960.

Dr. and Mrs. Bernard L. N. Morgan of Jacksonville announce the birth of a daughter, Alison, on December 17, 1960.

Dr. and Mrs. Charles R. Benton of Pensacola announce the birth of a daughter, Ann Caroline, on January 3, 1961.

Death — Member

Rose, Maurice J., Miami Beach.....December 11, 1960

Death — Other Doctors

Brockway, Robert O., Lake Worth.....September 16, 1960

COMPONENT SOCIETY NOTES

Dade

A feature of the January meeting of the Dade County Medical Association was presentation of "Medical Income Tax Problems: Possibilities and Pitfalls" by Mr. Walter Richardson, group supervisor, Audit Division, U. S. Internal Revenue Service.

DeSoto-Hardee-Glades

The DeSoto-Hardee-Glades County Medical Society has paid 100 per cent of its state dues for 1961.

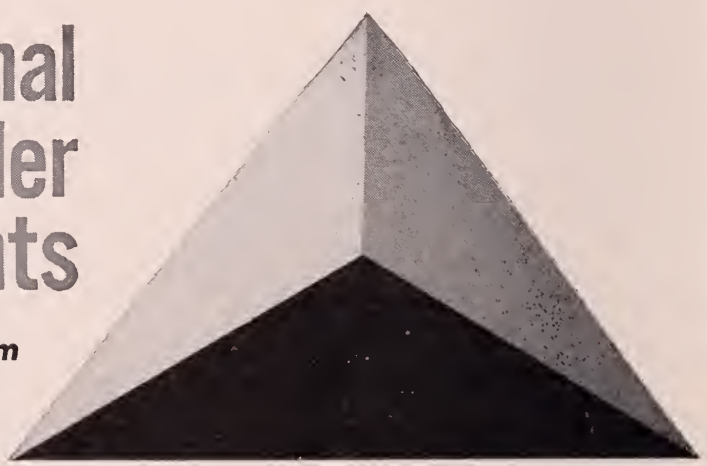
Taylor

The Taylor County Medical Society has paid 100 per cent of its state dues for 1961.

Volusia

Dr. Leo M. Wachtel of Jacksonville, President of the Florida Medical Association, was principal speaker at the January meeting of the Volusia County Medical Society. The title of his presentation was "People Who Live in Glass Houses Shouldn't."

3-dimensional support for older patients



BOLSTERS... ▲ *tissue metabolism*
▲ *interest, vitality*
▲ *failing nutrition*

NEW 1 small capsule every morning

GEVRESTIN®

Geriatric Vitamins-Minerals-Hormones-d-Amphetamine Lederle

Each capsule contains: Ethinyl Estradiol 0.01 mg. • Methyl Testosterone 2.5 mg. • d-Amphetamine Sulfate 2.5 mg. • Vitamin A (Acetate) 5,000 U.S.P. Units • Vitamin D 500 U.S.P. Units • Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate 1/15 U.S.P. Unit (Oral) • Thiamine Mononitrate (B_1) 5 mg. • Riboflavin (B_2) 5 mg. • Niacinamide 15 mg. • Pyridoxine HCl (B_6) 0.5 mg. • Calcium Pantothenate 5 mg. • Choline Bitartrate 25 mg. • Inositol 25 mg. • Ascorbic Acid (C) as Calcium Ascorbate 50 mg. • l-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental Iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as $CaHPO_4$) 35 mg. • Phosphorus (as $CaHPO_4$) 27 mg. • Fluorine (as CaF_2) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K_2SO_4) 5 mg. • Manganese (as MnO_2) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as $Na_2B_4O_7.10H_2O$) 0.1 mg. Bottles of 100, 1000.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Florida Medical Association
INVESTMENT TRUST

(A Restricted Retirement Trust)

Designed by and exclusively for members of the Florida Medical Association to provide a basic retirement program for each participant.

How the Plan Works

YOUR CONTRIBUTIONS

(Up to 10% of annual earnings, not to exceed $2,500.00 and not less than $300.00 annually)

are deposited with

TRUSTEE

Florida National Bank of Jacksonville

who

INVESTS

as follows

a) 40% in common stocks approved by Investment Trust Committee
b) 25% in bonds listed on the exchange as suitable for trust investment
c) 35% in a Pension Trust life contract underwritten by Pan-American Life Insurance Company

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REDUCED INVESTMENT COST through volume purchasing and administration by Trustee

EXTRA SAFETY OF PRINCIPAL because of greater diversification of funds

TAX EXEMPT PROBABILITIES in future legislation to provide tax deduction on contributions to a trust and tax deferment for the earnings on such contributions made by the trust

GUARANTEED COST OF TOMORROW'S ANNUITY AT TODAY'S RATES

BALANCED INVESTMENT program is designed to parallel inflation and hedge against depression.

For application and additional information

Contact FLORIDA MEDICAL ASSOCIATION INVESTMENT TRUST COMMITTEE,
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DISABILITY INCOME PROTECTION

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and

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Exclusively for Members and Their Families

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. . . Low cost as a result of the Association's buying power

. . . Broadest insuring clauses

Administered by: Marsh & McLennan, Incorporated, Atlanta and Miami

Underwritten by: Continental Casualty Company, Chicago, Illinois, and Columbia Casualty Company, New York

Detailed Program Information Available Through

Florida Medical Association Insurance Plan

P. O. Box 2411, Jacksonville 3, Florida

from depression to the right frame of mind



continuous, 24-hour cerebral oxygenation for the aging patient. By stimulating respiratory and circulatory function, GERONIAZOL TT* relieves mental confusion, depression, anxiety, and emotional instability—frequent problems in patients after forty—due to presenile changes in the vasculature of the brain. Notable benefit usually is seen within one to three weeks of therapy. It improves appetite, sleep pattern, and outlook—and GERONIAZOL TT* is non-hypertensive, non-excitatory.

Neither a tranquilizer nor a psychic energizer, GERONIAZOL TT* provides a physiologic stimulation of the cerebrum to permit the patient to adjust to his surroundings, become part of life itself again—and *attain the right frame of mind.*

References: 1. Curran, T. R., and Phelps, D. K.: Am. Pract. & Dig. Treat. *11:* 617, 1960. 2. Levy, S.: J.A.M.A. *153:* 1260, 1953. 3. Connolly, R.: W. Va. Med. J. *56:* 263, 1960.



Each TEMPOTROL contains: Pentylenetetrazol, 300 mg.; and Nicotinic Acid, 150 mg.

Indications: Respiratory and circulatory stimulant for the aged and debilitated with symptoms of mental confusion, depression, anxiety or arteriosclerotic psychosis.

Contraindications: None known in recommended dosage.

Dosage: One GERONIAZOL TT* tablet, b. i. d.

Supplied: Bottles of 42 tablets (3 weeks' treatment).

GERONIAZOL® TT*

*TEMPOTROL® (Time Controlled Therapy)

COLUMBUS PHARMACAL COMPANY affiliate of PHILIPS ROXANE, INC.

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PHYSICIAN WANTED: Rare opportunity in fast growing town of 11,000 needing one or two doctors. Excellent 75 bed, modern hospital. Well equipped office of recently deceased doctor including X-Ray, Laboratory, EKG, etc. County has population of 51,000 with only nine doctors. Adjoining county has no doctor. Financial assistance available. Write 69-385, P. O. Box 2411, Jacksonville, Fla.

DOCTOR'S OFFICE: Long established, unusual opportunity in fast growing town on ocean near Daytona Beach. Ground floor, main street. Reasonable lease. Write Mr. Gaynor Wiggins, 310 E. Colonial Dr., Orlando, Fla.

WANTED: Otolaryngologist to locate in a doctors building (12 physicians) in Fort Lauderdale. Excellent opportunity to rapidly build practice. Contact 69-398, P. O. Box 2411, Jacksonville, Fla.

WANTED: Pathologist for a south Florida county. Adequate work. Good financial opportunity. Sunshine daily. World's best fishing. Write Secretary, Monroe County Medical Society, Key West, Fla.

PATHOLOGIST: Certified, Florida licensed, wishes association with small to medium sized hospital or partnership. Write 69-403, P.O. Box 2411, Jacksonville, Fla.

PEDIATRICIAN WANTED: As associate with another pediatrician with large established practice in central Florida city. Good hospitals. Write 69-409, P. O. Box 2411, Jacksonville, Fla.

WANTED: General Practitioner urgently needed in Bonifay, northwest Florida. Office and housing available, new hospital. Contact John T. Grace, M.D. or Leon H. Winkler, Hospital Administrator.

WANTED: Director of medical services for large industrial plant located in central Florida. Graduate Grade A school internship completed. Florida license required. Industrial experience preferred but not mandatory. Well organized corporate medical program. Permanent location, adequate salary, excellent employee benefit plans. Apply to Industrial Relations Department, American Cyanamid Company, Brewster, Florida.

SPACE AVAILABLE: For clinic or medical center. 5,000 sq. ft. Ideally located in St. Petersburg, Florida on Main Boulevard. Ample parking. Air-conditioned. Will be remodeled to needs of responsible tenants. Inquire, Raymond M. Price, owner, R.R. 2, Box 484, Clearwater, Fla.

E.E.N.T.: Experienced, 37 years old, white, Protestant physician desires association with Ophthalmologist, hospital or clinic. Write 69-407, P. O. Box 2411, Jacksonville, Fla.

hearing improved...

tinnitus
and vertigo
relieved in
circulatory disturbances
of the
inner ear[1]



arlidin®
brand of nylindrin
hydrochloride N.N.D.

effective in twice as many patients

In patients with disturbances of the inner ear— impaired hearing, tinnitus or vertigo — Arlidin produced remission of their chief complaint in over 50% of cases. Rubin and Anderson state "we were very much encouraged, inasmuch as no other vasodilator that we have used has ever achieved more than a 25 per cent response."

"significant hearing improvement"

rationale:

The clinicians note that impairment in hearing, disturbance in balance, and tinnitus involving the inner ear "may be explained on the basis of labyrinthine artery insufficiency" due to spasm or obstruction of the vessels. Arlidin was found to be "superior to all other vasodilating measures" in increasing blood flow through these vessels and in allaying spasm.

WANTED: Internist, Board qualified or Board certified, to be associated with two Internists in group. Salary and percentage basis for the first year, with minimum guarantee of $15,000 with eventual full partnership. Office located on East coast between Palm Beach and Miami. Write 69-379, P. O. Box 2411, Jacksonville, Fla.

WANTED: General Practitioner or Internist. Excellent opportunity in Miami, Florida for one or two physicians. Association with established General Practitioner. Hospital privileges. Write 69-406, P. O. Box 2411, Jacksonville, Fla.

PEDIATRICIAN WANTED: Board eligible or certified to work with busy Ob-Gyn man in Northwest Florida. Florida license required. Write 69-408, P.O. Box 2411, Jacksonville, Fla.

WANTED: Surgical opportunity. Willing to do some GP. Florida license. American College and Board certified. Currently Chief Surgeon Veterans Hospital. Mature, capable, seasoned, sober and industrious. Association or individual practice. Write 69-400, P. O. Box 2411, Jacksonville, Fla.

WANTED: Young man to join general practice group in Florida resort city. Increasing percentage with guaranteed minimum. Good hospitals. At least two years approved internship or residency and Florida license required. Reply to 69-402, P.O. Box 2411, Jacksonville, Fla.

AVAILABLE: Established practice on Coral Way at reasonable terms. Practice may be had for cost of equipment. Large office with X-ray and modern equipment. Will introduce. Contact Medical Business Consultants, 1101 N. E. 79th St., Suite 205, Miami, Fla. Telephone PL 9-0230.

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aid to hearing in tablet form

arlidin

...“superior to all other vasodilating measures in its effect on the labyrinthine arteries.”

...efficacious where other vasodilators failed

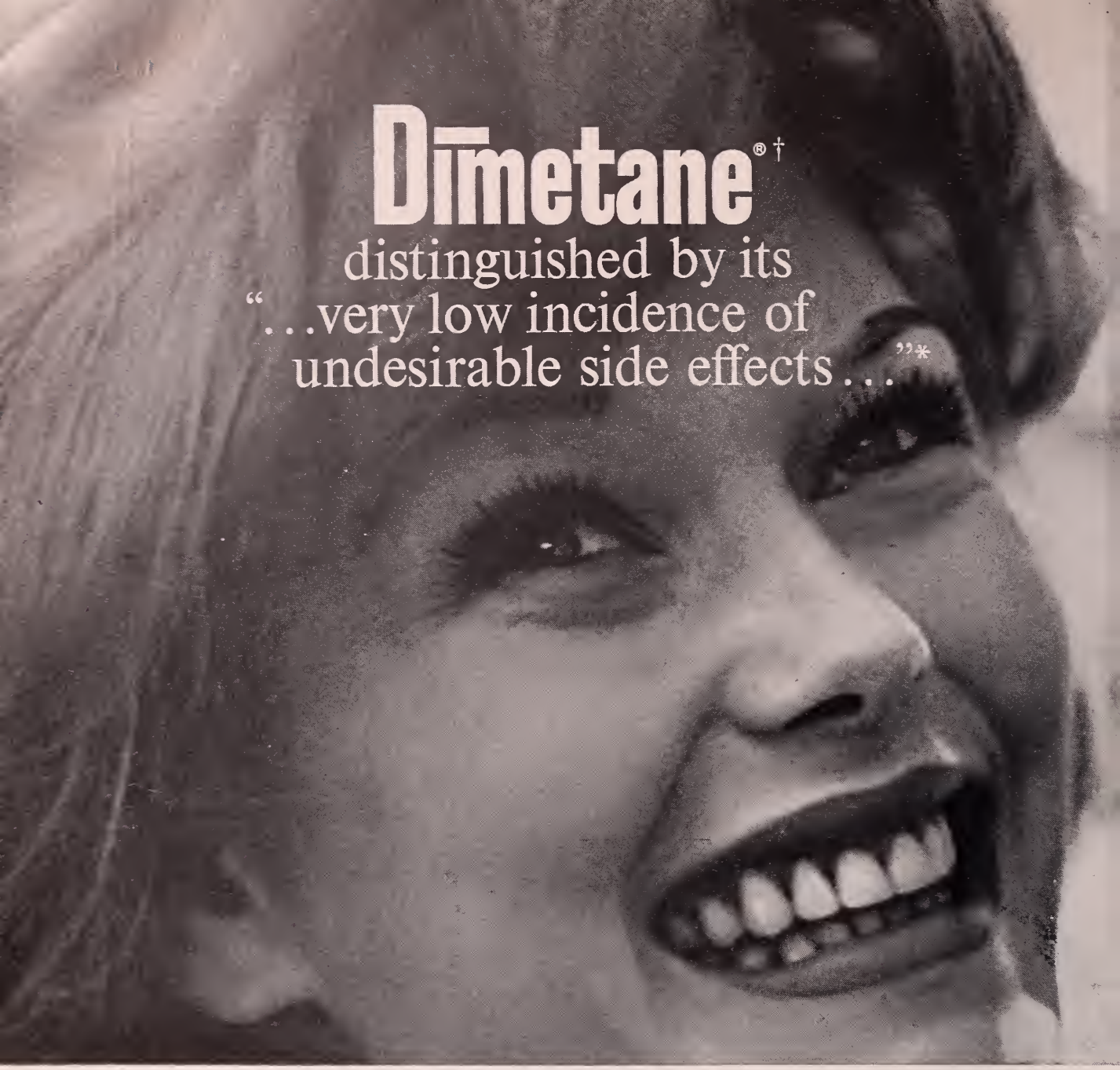


Arlidin is available in 6 mg. scored tablets, and 5 mg. per cc. parenteral solution. See PDR for dosage and packaging.

Protected by U. S. Patent Numbers: 2,661,372 and 2,661,373

1. Rubin, W., and Anderson, J. R.: Angiology 9:256, 1958.

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Dimetane®†

distinguished by its "...very low incidence of undesirable side effects..."*

even in allergic infants



FROM A CLINICAL STUDY* IN ANNALS OF ALLERGY

Patients	200 infants and children, ages 2 months to 14 years
Diagnosis	Perennial allergic rhinitis
Therapy	Dimetane Elixir
Results	in 149, *good* results / in 40, *fair* results
Side Effects	Encountered in *only* 7 patients (in all except one, the side effect was mild drowsiness)

In allergic patients *of all ages,* Dimetane has been shown to work with an effectiveness rate of about 90% and to produce an exceptionally low incidence of side effects. Complete clinical data are available on request to the Medical Department. *Supplied:* DIMETANE Extentabs® (12 mg.), Tablets (4 mg.), Elixir (2 mg./5 cc.), new DIMETANE-TEN Injectable (10 mg./cc.) or new DIMETANE-100 Injectable (100 mg./cc.).

Robins

*MC GOVERN, J. P., MC ELHENNEY, T. R., HALL, T. R., AND BURDON, K.D.: ANNALS OF ALLERGY 17:915, 1959.

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Suppose the physician visiting this patient finds that he has to be hospitalized. Certainly he wants an alert but not excited fellow who can respond to the history and physical on admission. Depending on the condition, of course, the thing to do is to give the patient one or two tablets of Dornwal before he ever leaves his home.

Dornwal will calm the patient but won't make him drowsy or give him feelings of depersonalization. And what's more, while Dornwal most assuredly tranquilizes, it won't interfere with most other medications that your subsequent examination or laboratory studies may indicate.

Since every man in general practice encounters such situations almost daily, it makes good sense to keep some tablets in one's bag, doesn't it? We will be glad to send you a supply.

Dosage: One or two 200 mg. tablets three times a day. Children, age 6 to 16, one or two 100 mg. tablets two times a day. Administration limited to three months' duration.

Supplied: 200 mg. yellow scored tablets, and 100 mg. pink tablets, each in bottles of 100 and 500.

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No absolute contraindications to the use of Dornwal are known. There have been no reports or evidence of habituation, addiction or drug tolerance in animal or clinical studies. Dornwal is relatively free from untoward effects when administered at recommended dosages.

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PDW-12

BOOK REVIEWS

Color Atlas and Management of Vascular Disease. By William T. Foley, M.D., F.A.C.P., and Irving S. Wright, M.D., F.A.C.P. Pp. 183. Illus. 192. Price, $18.00 New York. Appleton-Century-Crofts, Inc., 1959.

It would be good judgment for all physicians regardless of category to peruse the pages of this atlas. The authors were cognizant that black and white photographs could not portray the clinical significance of vascular disease and therefore undertook a great financial burden to reproduce 192 magnificent colored illustrations of the commonest blood vessel diseases. True to atlas form there is a minimum of written description which really is not an inadequacy because the color pictures of the integumentary changes are self explanatory. The book is based on 94 case histories which are briefly discussed in regards to diagnosis, pathogenesis and therapy. The color photographs in the text may be obtained in transparency form for educational purposes. Because this manuscript is excellent review material, hospital libraries should shelve it for their busy physicians.

Clifford C. Snyder, M.D.

Manual of Skin Diseases. By Gordon C. Sauer, M.D. Pp. 269. 151 Illustrations and 28 Color Plates. Price, $9.75. Philadelphia, J. B. Lippincott Company, 1959.

The physician, regardless of his type of practice, encounters disorders of the skin. When his knowledge is limited, he refers the case to a colleague better acquainted with the patient's discomfort. This concise and informative text provides the nondermatologic specialist with the practical information he is searching for without confusion. The author should be highly commended for the approach he uses in presenting this complicated medical subject. There are no prolonged discussions nor deviated wanderings into vast nonessential theories, but instead concrete and complete factual information. For simplicity, the text is divided into two sections; the first introduces the reader to diagnosis and treatment of the more common diseases of the skin, whereas the last section is devoted to a dictionary index of dermatology including unusual and even rare integumental terms. The author is unique in simplifying the dermatologic terminology for his readers. The entire text is profuse with extravagant colored illustrations, extensive drawings and even many instructive silhouettes of various skin manifestations. Diagnoses are enhanced by separating the disease conditions into body locations, seasons, ages, sexes, races, and whether they are contagious or infectious. For the price this text is the best on the medical book market today.

Clifford C. Snyder, M.D.

Current Medical References. Edited by Paul J. Sanazaro, M.D. Pp. 535. Price $3.50. Los Altos, Calif., Lange Medical Publications, 1959.

This of course is a book without a text. The author offers a selective bibliography on a rather complete list of topics. These include such general topics as shock, pain and fever, as well as general reviews of subjects such as diabetes mellitus, and more specific clinical problems such as hormonal therapy of cancer of the breast. The handbook is a group effort to provide a list of references on the clinical aspects of medical diseases and disorders. It is a compilation of some of the more useful and significant references from literature of the past 20 years. It is obviously not a source of related literature on a particular subject, nor is it a complete bibliography of any subject. The role of this book is therefore probably limited to supplying a busy physician or intern a quick reference

(Continued on page 1078)

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New 4% Xylocaine® HCl applied topically to the larynx, pharynx, and trachea, gives fast, intense and profound anesthesia for endoscopic procedures. Whenever effective anesthesia of the mucosa of the eye, ear, nose and throat is required, topical Xylocaine HCl 4% offers all these advantages ▪ fast anesthetic action ▪ intense depth of anesthesia—not just surface analgesia ▪ effectiveness in small volumes—average 4 cc. ▪ patients experience no pain ▪ relatively nonirritating and nonsensitizing ▪ side effects are extremely rare. In ophthalmology, Xylocaine HCl 4% used both topically and by retrobulbar injection, provides fast, deep, and enduring anesthesia for a wide variety of major as well as minor surgical techniques. Xylocaine® HCl (brand of lidocaine*)

Administration and Dosage: For topical anesthesia, Xylocaine HCl 4% may be applied as a spray or with cotton applicators or packs, and by instillation into a cavity. The suggested volume ranges, for adults, from one to five cc. (40-200 mg.). For children, debilitated and aged patients, dosages should be proportionately reduced. Prior to removal of foreign bodies from the eye, examination of corneal lacerations, cauterization of corneal ulcers, and other surgical and diagnostic procedures, 2 to 3 drops of Xylocaine HCl 4% will usually produce adequate anesthesia. *How Supplied:* For Transtracheal and Retrobulbar Injection and Topical Application—Sterile aqueous solution dispensed in 5 cc. color-break ampules, packed 10 ampules to a carton. For Topical Use Only—Aqueous solution in 50 cc. screw cap bottles, individually cartoned.

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The cigarette that made the Filter Famous!



It's true. Kent's enormous rise in popularity—with all the attendant magazine and newspaper stories—really put momentum to the trend toward filter cigarettes!

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Kent with the Micronite filter refines away harsh flavor . . . refines away hot taste . . . makes the taste of a cigarette mild.

That's why you'll feel better about smoking with the taste of Kent.

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ANNOUNCING—
SPECIFICALLY FOR
INFECTIONS DUE TO
"RESISTANT" STAPHYLOCOCCI

AN ENTIRELY NEW SYNTHETIC
"STAPH-CIDAL" PENICILLIN

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

UNIQUE—BECAUSE IT
RETAINS ANTIBACTERIAL
ACTIVITY IN THE PRESENCE OF
STAPHYLOCOCCAL PENICILLINASES
WHICH INACTIVATE
OTHER PENICILLINS

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NEW SYNTHETIC PENICILLIN FOR "RESISTANT" STAPH

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OFFICIAL PACKAGE CIRCULAR
November, 1960

STAPHCILLIN™

(sodium dimethoxyphenyl penicillin)

For Injection

DESCRIPTION

STAPHCILLIN is a unique new synthetic parenteral penicillin produced by Bristol Laboratories for the specific treatment of staphylococcal infections due to resistant organisms. Its uniqueness resides in its property of resisting inactivation by staphylococcal penicillinase. It is active against strains of staphylococci which are resistant to other penicillins.

Each dry filled vial contains: 1 Gm. STAPHCILLIN (sodium dimethoxyphenyl penicillin), equivalent to 900 mg. dimethoxyphenyl penicillin activity.

INDICATIONS

STAPHCILLIN is recommended as specific therapy only in infections due to strains of staphylococci resistant to other penicillins, e.g.:

Skin and soft tissue infections: cellulitis, wound infections, carbuncles, pyoderma, furunculosis, lymphangitis and lymphadenitis.

Respiratory infections: staphylococcal lobar or bronchopneumonia, and lung abscesses combined with indicated surgical treatment.

Other infections: staphylococcal septicemia, bacteremia, acute or subacute endocarditis, acute osteomyelitis and enterocolitis.

Infections due to penicillin-sensitive staphylococci, streptococci, pneumococci and gonococci should be treated with Syncillin® or parenteral penicillin G rather than STAPHCILLIN. Treponemal infections should be treated with parenteral penicillin G.

DOSAGE AND ADMINISTRATION

STAPHCILLIN is well tolerated when given by deep intragluteal or intravenous injection.

As is the case with other antibiotics, the duration of therapy should be determined by the clinical and bacteriological response of the patient. Therapy should be continued for at least 48 hours after the patient has become afebrile, asymptomatic and cultures are negative. The usual duration has been 5-7 days.

Intramuscular route: The usual adult dose is 1 Gm. every 4 or 6 hours. Infants' and children's dosage is 25 mg. per Kg. (approximately 12 mg. per pound) every 6 hours.

Intravenous route: 1 Gm. every 6 hours using 50 ml. of sterile saline solution at the rate of 10 ml. per minute.

Warning: Solutions of STAPHCILLIN and kanamycin should not be mixed, as they rapidly inactivate each other. Data on the results of mixing STAPHCILLIN with other antibiotics are being accumulated.*

DIRECTIONS FOR RECONSTITUTION

Add 1.5 ml. sterile distilled water or normal saline to a 1 Gm. vial and shake vigorously. Withdraw the clear, reconstituted solution (2.0 ml.) into a syringe and inject. The reconstituted solution contains 500 mg. of STAPHCILLIN per ml. Reconstituted solutions are stable for 24 hours under refrigeration.

For intravenous use, dilute the reconstituted dose in 50 ml. of sterile saline and inject at the rate of 10 ml. per minute.

*This statement supersedes that in the Official Package Circulars dated September and/or October, 1960.

(continued)

OFFICIAL PACKAGE CIRCULAR
(continued)

MICROBIOLOGICAL AND PHARMACOLOGICAL PROPERTIES

In vitro studies show that STAPHCILLIN is a bactericidal penicillin with activity against staphylococci resistant to penicillin G. Strains of staphylococci so far tested have been sensitive to STAPHCILLIN *in vitro* at concentrations of 1-6 mcg. per ml. These levels are readily attained in the blood and tissues by administration of STAPHCILLIN at the recommended dosage. This unique attribute is probably due to the fact that STAPHCILLIN is stable in the presence of staphylococcal penicillinase. STAPHCILLIN also resists degradation by *B. cereus* penicillinase. The antimicrobial spectrum of STAPHCILLIN with regard to other microorganisms is qualitatively similar to that of penicillin G; but considerably higher concentrations of STAPHCILLIN are required for bactericidal activity than is the case with penicillin G.

STAPHCILLIN is rapidly absorbed after intramuscular injection. Peak blood levels (6-10 mcg./ml. on the average after a 1.0 Gm. dose) are attained within 1 hour; and then progressively decline to less than 1 mcg. over a 4 to 6 hour period. It is poorly absorbed from the gastrointestinal tract. STAPHCILLIN is rapidly excreted by the kidney.

As shown by animal studies, STAPHCILLIN is readily distributed in body tissues after intramuscular injection. Of the tissues studied, highest concentrations are reached in the kidney, liver, heart and lung in that order; the spleen and muscles show lower concentrations of the antibiotic. STAPHCILLIN diffuses into human pleural and prostatic fluids, but its diffusion into the spinal fluid has not yet been completely studied. However, one patient with meningitis showed a significant concentration in his spinal fluid while on STAPHCILLIN therapy.

Toxicity studies with STAPHCILLIN and penicillin G in animals show that they have approximately the same low order of toxicity.

Certain staphylococci can be made resistant to STAPHCILLIN in the laboratory, but this resistance is not related to their penicillinase production. During the clinical trials, no STAPHCILLIN-resistant strains of staphylococci were observed or developed; the possibility of the emergence of such strains in the clinical setting awaits further observation.

PRECAUTIONS

During the clinical trials, several mild skin reactions, e.g., itching, papular eruption and erythema were observed both during and after discontinuance of STAPHCILLIN therapy. Patients with histories of hay fever, asthma, urticaria and previous sensitivity to penicillin are more likely to react adversely to the penicillins. It is important that the possibility of penicillin anaphylaxis be kept in mind. Epinephrine and the usual adjuvants (antihistamines, corticosteroids) should be available for emergency treatment. Because of the resistance of STAPHCILLIN to destruction by penicillinase, parenteral *B. cereus* penicillinase may not be effective for the treatment of allergic reactions. Information with regard to cross-allergenicity between penicillin G, penicillin V, phenethicillin (Syncillin) and STAPHCILLIN is not available at present. If superinfection due to Gram-negative organisms or fungi occurs during STAPHCILLIN therapy, appropriate measures should be taken.

SUPPLY

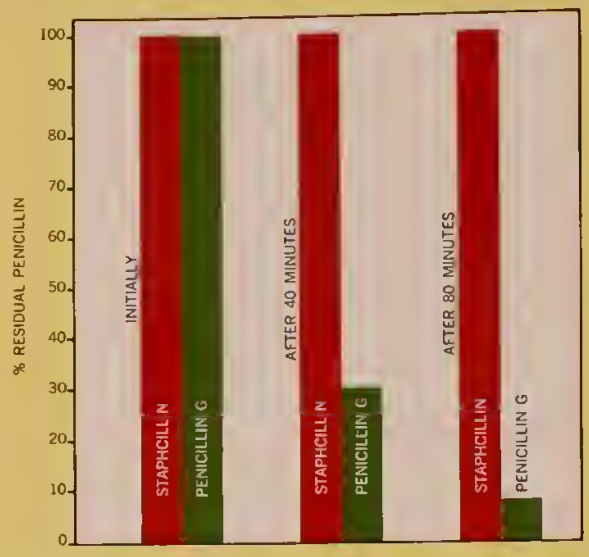
List 79502 — 1.0 Gm. dry filled vial.

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UNIQUE SYNTHETIC STAPHYLOCIDAL PENICILLIN

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In the presence of staphylococcal penicillinase, STAPHCILLIN remained active and retained its antibacterial action. By contrast, penicillin G was rapidly destroyed in the same period of time. *(After Gourevitch et al., to be published)*

Specifically for "resistant" staph...

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

The failure of staphylococcal infections to respond to penicillin therapy is attributed to the penicillin-destroying enzyme, penicillinase, produced by the invading staphylococcus.

Unlike other penicillins:

1 STAPHCILLIN is effective because it retains its antibacterial activity despite the presence of staphylococcal penicillinase.

2 The clinical effectiveness of STAPHCILLIN has been confirmed by dramatic results in a wide variety of infections due to "resistant" staphylococci, many of which were serious and life-threatening.

Like other penicillins:

STAPHCILLIN has no significant systemic toxicity. It is well tolerated locally, and pain or irritation at the injection site is comparable to that following the injection of penicillin G. *In occasional cases, typical penicillin reactions may be experienced.*

PROFESSIONAL INFORMATION SERVICE — The attached Official Package Circular provides complete information on the indications, dosage, and precautions for the use of STAPHCILLIN. If you desire additional information concerning clinical experiences with STAPHCILLIN, the Medical Department of Bristol Laboratories is at your service. You may direct your inquiries via collect telephone call to New York, PLaza 7-7061, or by mail to Medical Department, Bristol Laboratories, 630 Fifth Ave., N. Y. 20, N. Y.

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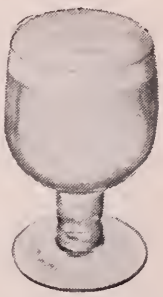
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How to help your patient stick to a low calorie diet

The secret ingredient in a successful diet is acceptance. A low calorie diet that lets the patient work out equivalent variations will win his approval. A too-rigid diet begs to be broken. Pictured are dishes any dieter would find appetizing: chicken flavored with garlic, fruit-garnished gelatin, grapefruit, raw carrot, celery, pepper and radish nibbles. Variations might be broiled fish, simple green salads. All can be interestingly seasoned, attractively served, to keep the patient's enthusiasm from flagging.



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104 calories, 8 oz. glass
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Sustained Action Tablets

Also available as Black Cherry Flavored COVANAMINE LIQUID; COVANAMINE EXPECTORANT provides the liquid formula plus glyceryl guaiacolate.

Each Sustained Action (continuous release) COVANAMINE tablet contains: phenylephrine HCl 15 mg., phenylpropanolamine HCl 25 mg., Chlorpheniramine maleate 4 mg., and pyrilamine maleate 25 mg.

COVANAMINE LIQUID provides ¼ the tablet formula in each 5 ml. teaspoon.

COVANAMINE EXPECTORANT provides the liquid formula plus glyceryl guaiacolate 100 mg. per teaspoon.

Dosage: Tablets: Adults—1 tablet (swallowed without chewing) morning, mid-afternoon and at bedtime; Children, 6 to 12 years—½ tablet. Liquid and Expectorant: Adults—2 teaspoonfuls every four hours. Children 6 to 12 years—1 teaspoonful every four hours; 1 to 6 years—½ teaspoonful every four hours; under 1 year—¼ teaspoonful every four hours.

VANPELT AND BROWN, INC. Richmond, Virginia

(Continued from page 1072)

to a reasonably recent review of a particular subject. Inasmuch as that requires a reasonable medical library, one wonders if it would supplant a small collection of up-to-date text books which would contain a similar bibliography and also a review of the subjects.

John B. Liebler, M.D.

Nine Months' Reading: *A Medical Guide for Pregnant Women.* By Robert E. Hall, M.D. Pp. 191. Illustrated. Price, $2.95. Garden City, N. Y., Doubleday & Company, Inc., 1960.

The purpose of this book is to satisfy the healthy intellectual curiosity of the modern pregnant woman. This objective is accomplished in a reassuringly thorough, refreshingly candid and remarkably readable way. In these pages a capable young doctor and the father of four tells today's expectant mother what she wants to know. He discusses every phase of pregnancy and birth from selecting a doctor and his fees to the postpartum visit. He tells about the development of the fetus, symptoms, sensations and complications of pregnancy, labor and delivery, hospital procedures, and the first weeks of motherhood. The more controversial issues of modern obstetrics, such as natural childbirth, induction of labor, rooming-in, and breast feeding, are discussed with candor and thoroughness. Although he presents both sides, his own views are readily apparent. He is definitely skeptical of natural childbirth and very much in favor of breast feeding. He also discusses the relatively minor matters such as whether to smoke, work, travel, or exercise. A detailed preview of what to expect in the delivery room, a lucid summary of modern anesthetics, and a helpful glossary of common obstetrical terms are among the many other features of this comprehensive book designed for reading and reference throughout pregnancy. The author is a practicing obstetrician and gynecologist at Sloane Hospital for Women, a division of the Columbia-Presbyterian Medical Center in New York City, and he also teaches obstetrics at Columbia Medical School.

Clinical Obstetrics and Gynecology, Volume 3, Number 1, **Symposium on Obstetric Emergencies,** edited by Martin L. Stone, M.D., and **Symposium on Pediatric Gynecology,** edited by John W. Huffman, M.D. March 1960. Pp. 1-264. Price, $18.00 by subscription for four consecutive numbers. New York, Paul B. Hoeber, Inc., 1960.

The Symposium on Obstetric Emergencies presented here points out the ever present danger and possibility of obstetric emergencies. The essayists were chosen because of their wide experience and special interest in the subjects presented and each was asked to emphasize recognition and management. The subjects covered include anesthesia for obstetric emergencies, failed forceps, the management of transverse presentation, rupture of the uterus, eclamptogenic toxemia, severe abruptio placentae, postpartum hemorrhage, acute renal failure, pregnancy complicated by acute abdominal emergencies and cardiac arrest in obstetrics. One of the distinguished contributors was Dr. James Henry Ferguson, of Miami, Chairman of Obstetrics and Gynecology, University of Miami School of Medicine and Jackson Memorial Hospital.

The Symposium on Pediatric Gynecology is the publisher's response to an articulate request for a collection of timely papers on genital disorders in childhood. Each of the authors has made significant contributions to his subject in the past and each has utilized, in preparing his essay, a wealth of experience and observation not easily

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The all-new Dual-Speed EK-III sets a new standard in high fidelity electrocardiography for recording the fine details of rapid small deflections. With its sensitive recording system the dual-speed paper drive with 50 mm. per second speed to enlarge the horizontal dimensions of heart complexes becomes highly important. Switch from standard 25 mm. to 50 mm. and back again with no transitional lag.

Special Features:
Simplified top-loading paper drive, single 4-position Amplifier/Record switch, convenient ground indicator, all-new single-tube stylus, jacks for cardioscope and D.C. Input connections, rapid lead selection, standard 50 mm. records, modern, clean design.
Without sacrificing quality or utility, the EK-III unit is compact and weighs only 22½ pounds. Call or write us for full details; and if you wish we will be glad to demonstrate the EK-III in your office.

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can make a difference to your patient/ reduce recovery time/add comfort to convalescence

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Precautions: VARIDASE has no adverse effect on normal blood clotting. Care should be taken in patients on anticoagulants or with a deficient coagulation mechanism. When infection is present, VARIDASE Buccal Tablets should be given in conjunction with antibiotics.

Dosage: One buccal tablet four times daily usually for five days. To facilitate absorption, patient should delay swallowing saliva.

Supplied: Each tablet contains 10,000 Units Streptokinase, 2,500 Units Streptodornase. Boxes of 24 and 100 Tablets.



Lifts depression...as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety...rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient – *they often aggravate anxiety and tension.*

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A Manual of Tropical Medicine. By George W. Hunter, III, Ph.D., Col. U.S.A. (Ret.), William W. Frye, Ph.D., M.D., Sc.D.(Hon.), and J. Clyde Swartzwelder, Ph.D. Ed. 3. Pp. 892. Illus. 323. Price, $15.00. Philadelphia, W. B. Saunders Company, 1960.

This well organized text presents straightforward, useful information on the etiology, epidemiology, pathology, clinical characteristics, diagnosis, treatment and control of important bacterial, parasitic, viral, mycotic and nutritional diseases encountered in the tropics, and frequently in temperate climates. This new third edition has been drastically rewritten. Thirty-six new authorities have collaborated, many new illustrations have been added, and the latest drugs effective against tropical diseases are included. A separate section is devoted to a wide variety of laboratory diagnostic methods. The varied diseases and disorders covered range from coxsackie virus infections to fire ant stings.

Dr. Hunter, the senior author of the Manual, is Lecturer in Microbiology at the College of Medicine of the University of Florida. Four other faculty members are among the contributors: Dr. Victor M. Arean, Associate Professor of Pathology; Dr. Paul D. Ellner, Instructor, Department of Microbiology; Dr. Henry Edmund Meleney, Visiting Professor of Medicine; and Dr. Emanuel Suter, Professor and Head, Department of Microbiology. Dr. Hunter pointed out that the desire of Americans to visit other areas of the world has resulted in international tourism as a major industry and this, in turn, has created a need for improved training of physicians in the recognition and treatment of tropical and semitropical diseases.

Pain and Itch: *Nervous Mechanisms. CIBA Foundation Study Group No. 1.* Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A. Pp. 120. Illus. 41. Price, $2.50. Boston, Little, Brown and Company, 1959.

Recorded within the covers of this booklet are the papers and discussions presented on March 10, 1959, in Basle, Switzerland, by a distinguished group of investigators interested in this subject. This one day conference, presided over by the distinguished Rt. Hon. Lord Adrian, O.M., featured papers dealing with the peripheral anatomic arrangement of nerves which serve pain and itch, the peripheral nervous mechanisms of these modalities, central sensory pathways, thalamic and cortical reception, and finally studies on the mechanisms of pain in trigeminal neuralgia. This is a monograph which will be of great interest to investigators in this field but of little interest to the practicing physician.

William M. Straight, M.D.

Handbook of Poisoning: Diagnosis and Treatment. By Robert H. Dreisbach, M.D., Ph.D. Ed. 2. Pp. 476. Price, $3.50. Los Altos, Calif., Lange Medical Publications, 1959.

This is another in the Lange Medical Publications pocket-sized reference series. Crammed with factual data,

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William M. Straight, M.D.

Doctor Strand. By Boris Sokoloff. Pp. 205. Price $3.50. New York, Vantage Press, 1960.

In this novel the author probes the motivations of researchers in a fictional research center whose work is directed toward the solution of the enigma of cancer and their efforts to find its cure. Throughout the book one is impressed with how frequently reference is made to the "fight against cancer" almost as if an all-out war has been declared and is being fought. The doctors, if viewed as the soldiers in this struggle, have placed their personal lives as of secondary importance when outside forces—home, personal life, love—make themselves felt. The basic rules of scientific life are violated and the concerted battle is interrupted. From this the story evolves. Dr. Sokoloff works well with the participants' thoughts and actions.

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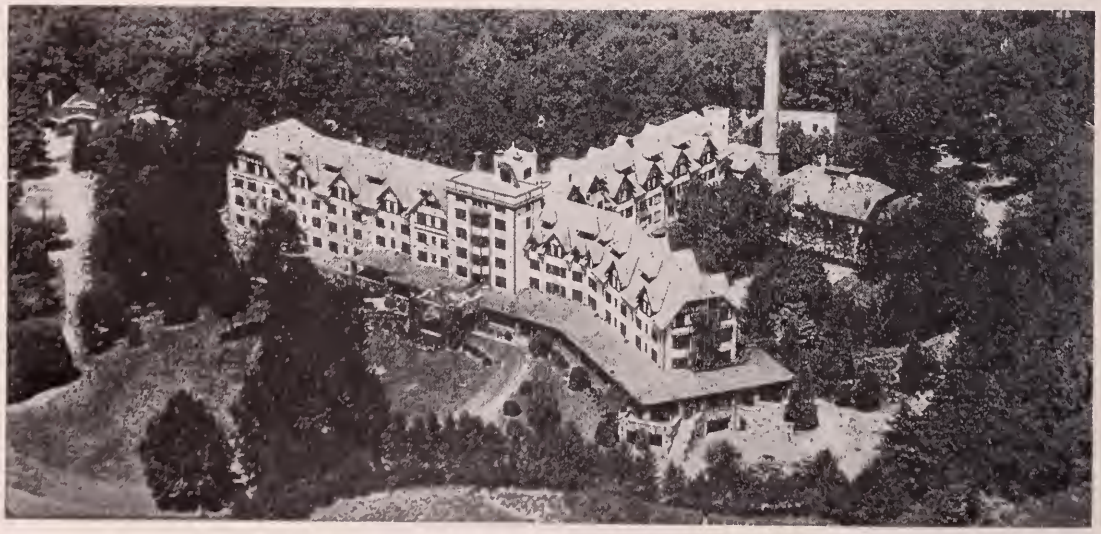
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Duval	Sidney Stillman, Jacksonville	Robert J. Brown, Jacksonville	1st Tues.	358
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*Pomeranze, J.: J. New York M. Coll. *1*:32, 1959.

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1. Clein, N. W.: Pediat. Clin. North America, Nov., 1954, pp. 949-962.

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2. Cornbleet, Theodore: Discaid lupus erythematosus treated with Plaquenil, A.M.A. Arch. Dermat. 73:572, June, 1956.

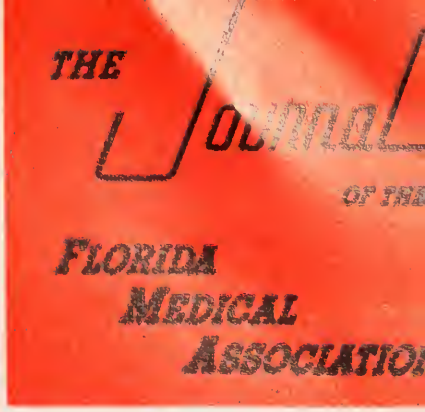
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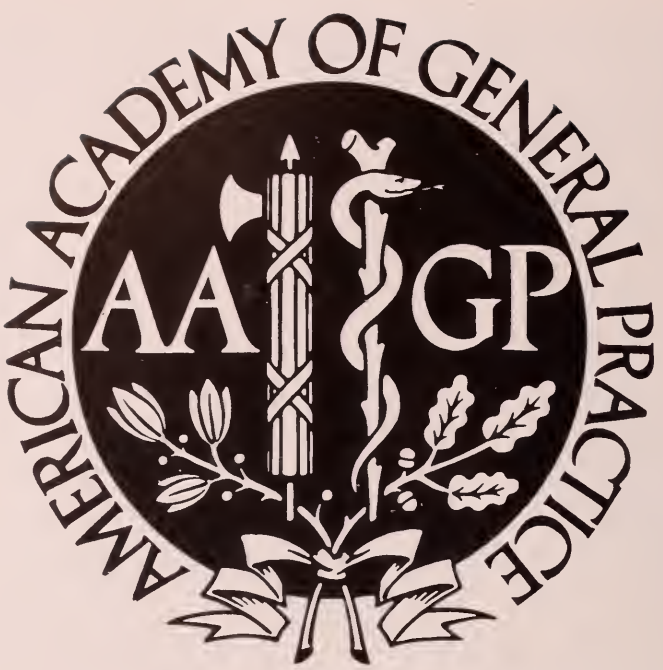
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REFERENCES: 1. Carpenter, E. B.: Southern M.J. 51:627, 1958. 2. Forsyth, H. F., J.A.M.A. 167:163, 1958. 3. Hudgins, A. P.: Clin. Med. 6:2321, 1959. 4. Grisolia, A., and Thomson, J. E. M.: Clin. Orthopaedics 13:299, 1959. 5. Lewis, W. B.: California Med. 90:26, 1959. 6. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 7. Park, H. W.: J.A.M.A. 167:168, 1958. 8. Plumb, C. S.: Journal-Lancet 78:531, 1958. 9. Poppen, J. L., and Flanagan, M. E.: J.A.M.A. 171:298, 1959. 10. Schaubel, H. J.: Orthopedics 1:274, 1959.

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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

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arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W. and Fong, T. C. C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

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8. Duncan, G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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Late Results in Vascular Surgery

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Vascular surgery in not particularly new; as in the case of most other branches of surgery, it had its beginning back in antiquity. For example, Vesalius has been quoted as mentioning in 1542 the insertion of a reed into the femoral arteries of animals to improve the blood supply to the foot.[1] The femoral artery was exposed, ligated and incised, after which a reed of the same caliber as the vessel was inserted into the proximal and distal ends of the artery. Following division of the ligatures, pulsative blood flow was restored to the foot. As in all other branches of medicine, however, the tremendous improvements in diagnostic and therapeutic methods, particularly during the last few decades, have completely revitalized the field of vascular surgery.

The most constant factor in the changing aspect of vascular surgery has been in the field of replacement grafts. The development of preservation methods for homografts was soon followed by the introduction of various plastics and this in turn was followed by the observation that a rather high percentage of homografts was failing in the late postoperative phase. Such rapid changes in techniques and materials make it imperative that we surgeons stop frequently and take a look backwards at what we have been doing in this particular field and what has happened to our patients. The rewards are clearly defined by the well known quotation: "He who cannot remember the past is condemned to repeat it."

From Feb. 1, 1956, through Feb. 1, 1960, 154 patients were seen requiring various types of arterial surgery. It is important to point out that the 154 cases of this series are consecutive in order and represent the total cases seen in the particular groups of disease processes which will be discussed in this report. Follow-up examination was completed by direct patient contact in practically all instances except in a few cases where the contact had to be by letter or by communication with the patient's private physician. In general, the patients fall into one of several classifications, the first comprising those patients in whom there was a sudden interruption in vascular continuity, either precipitated by arterial trauma or secondary to embolization. The remaining groups of patients either had aortic aneurysms or peripheral aneurysms, or were subject to degenerative occlusive disease processes which will be grouped as a unit.

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Emboli

Nineteen patients presented with the problem of embolization with a time interval ranging from one hour to two weeks in duration. Of this group 12 had involvement of the major arterial blood supply to an extremity, in three of whom the axillary or brachial artery was involved, while in the remainder the emboli all lodged in the femoral or popliteal artery. The remaining seven patients all had aortic saddle emboli.

One patient of the group of 12 examples of major extremity occlusion had subsequent amputation after an incomplete removal of an embolus and secondary thrombus from the popliteal artery; extensive distal clot precluded return of circulation, and a lumbar sympathectomy was of no benefit. The remaining 11 patients all survived the original procedure without major complications

and follow-up has averaged from three months to two and one-half years. Only one patient has residual claudication in her foot, but is able to walk without too much difficulty, some two years following removal of a superficial femoral artery embolus. This patient was operated on four days after the original onset, and again extensive distal clot made complete restoration of circulation impossible. One patient expired nine months following surgery of an unrelated cause, and a second patient had recurrence of embolization and expired two and one-half years following removal of a femoral embolus. This recurrent embolization occurred in the superior mesenteric artery. Of the remaining eight patients, all of whom are asymptomatic, seven are on continued anticoagulants in one form or another. The remaining seven patients in this group all suffered the extremely serious situation of an aortic saddle embolus and only one of the group survived the surgery for any period of time. This patient was operated on one year ago and made an uneventful recovery without further difficulty. She is being maintained on anticoagulants because of her cardiac disease. One other patient survived surgery, but had a fatal myocardial infarction two months later during a second bout of surgery. The remainder of the patients were all critically ill at the time of surgery; although they survived the surgical procedure, they all died either of their original cardiac disease or cerebral embolization during the immediate postoperative phase.

COMMENT. — Several observations can be drawn from the follow-up of this particular group of patients. First and foremost is the importance of the use of heparin therapy. As pointed out by Guynn and Reynolds,[2] heparin should be administered immediately after the diagnosis or suspicion of arterial occlusion is entertained, and preferably by an intravenous route. This therapy affords considerable protection against propagation of a thrombus during the time required for hospitalization and prior to beginning any surgical therapy. The prevention of this distal thrombus is the one single factor around which survival of the extremity depends. Certainly the one patient in this series who had amputation might well have been saved the loss of an extremity by the use of heparin therapy during the 10 hours before surgery.

A second observation concerns the length of time the embolus has been present; as has been pointed out by other groups, emboli can be removed successfully after a prolonged period of time, provided distal thrombosis has not occurred and provided the limb is still viable.[3,4] Two of our patients had emboli for a period of four days prior to surgery, while one had gone two weeks with an axillary occlusion. All patients had successful embolectomies and had no residual difficulty except for one patient with minor distal claudication. The third observation, which again is shared by many authors, consists of the use of continued or long term anticoagulants following embolization. It would certainly appear in this particular group that recurrent embolization has been prevented by the use of long term anticoagulants, and the only patient in whom embolization did recur had not been receiving anticoagulants. Prophylactic cardiac surgery also plays a part in this program, as has been pointed out many times. One patient in our series had a mitral commissurotomy nine months following the removal of a distal embolus and has done well during the past two years.

Arterial Trauma

The other form of sudden interruption in arterial continuity encountered in patients during the past four years was manifested by a group of nine patients who had varying types of arterial trauma. Three patients had acute lacerations with knife wounds, two of these surviving the original surgery with an intact extremity. The third patient was brought in 24 hours following the original injury and distal clot prevented re-establishment of blood flow, with subsequent amputation of the lower extremity. Of the other two patients, one had a graft which subsequently was occluded because of secondary infection in the wound, although his extremity was later saved by a lumbar sympathectomy. He was subsequently returned to an Air Force Base Hospital for physiotherapy and at last report, some six weeks following surgery, was steadily improving. The other patient suffered massive hematoma and infection in the wound where an end to end anastomosis had been performed with subsequent sloughing out of the suture line. The common femoral artery had to be primarily ligated, and the extremity of this patient was likewise saved, but undoubtedly considerable claudication will develop in the future. This case is only two months old at the present time. Five other patients received gunshot wounds of various vessels, one in the abdominal aorta. This patient was subjected to an exploratory operation within one hour of the accident, the perforation of the

aorta was closed, and he has done exceedingly well for two years. Of the remaining four patients with wounds of the arterial supply to the lower extremity, two had difficulty with distal clot, one patient losing his leg due to retained clot despite resumption of arterial flow in the main tibial vessels. The other patient had residual claudication, but was doing well in physiotherapy at the end of one month when returned to an Air Force Base Hospital. The other two patients have gone two months and six months respectively, with an end to end anastomosis in one case, and a ¾ inch Teflon graft in the other. Both patients made an excellent recovery following resumption of normal arterial circulation. Therapy received by the remaining patient in this group with arterial trauma consisted of an endarterectomy for brachial artery occlusion two months old at the time of surgery, and this patient responded excellently to an endarterectomy. Two months postoperatively he had full use of his arm and was then lost to follow-up, approximately one and one-half years ago.

Comment. — The late results in those patients who survived original arterial trauma and in whom, in particular, there is no complicating distal clot would indicate that these patients do well following satisfactory repair. The site of the trauma, of course, has tremendous bearing on the eventual outcome, as the smaller the vessel the more precarious the type of surgical repair and its ultimate success. This is particularly true where grafting must be accomplished as the smaller-sized vessels in this particular group, namely the popliteal, are exceedingly difficult to graft. One homograft occluded, as mentioned, whereas a Teflon graft in the superficial femoral artery some 6 inches away has remained patent since its insertion. The presence of infection also makes these cases extremely difficult and has a direct bearing on the eventual outcome. The loss of an arterial repair or an arterial graft due to secondary infection either results in the loss of the extremity or fairly severe claudication as noted in the examples cited. Having survived the original injury and the essential surgery, these patients have a good prognosis. For them, contrary to the patients with embolization, anticoagulation therapy has been found unnecessary.

Peripheral Aneurysms

Fifteen patients with varying types of peripheral aneurysm were treated during the past four years. Only two of the entire group had elective resection of the aneurysm; in other words, they were not admitted as presenting acute problems of arterial insufficiency, nor did they have the other complications of this particular type of lesion. In one, a massive aneurysm involving the brachial artery was replaced with a fabric graft, and in the other a popliteal aneurysm likewise had a fabric graft replacement. All other patients in this group were admitted either with acute arterial insufficiency or other complications of peripheral aneurysms including thrombosis and chronic arterial insufficiency. One patient with a superficial femoral aneurysm had a cutaneous fistula from which she had had recurrent hemorrhages.

In four patients of this group, the aneurysms were considered to be post-traumatic, one involving the common femoral artery while the other three involved the superficial femoral artery. One of the latter had an associated venous fistula. These four patients all had direct resection with replacement by varying types of fabric grafts. The outcome has been good, although one patient, in the case involving the cutaneous fistula from a superficial femoral aneurysm, subsequently lost the graft due to secondary infection. This patient had adequate collateral circulation, however, and although the superficial femoral artery had to be ligated and the graft removed, she does not complain of residual claudication. Follow-up in these particular patients covers nine months, 14 months, three years, and three and one-half years. Another patient was admitted with acute carotid arterial insufficiency secondary to a carotid aneurysm, which was subsequently resected and the insufficiency corrected; the patient has now done well for two months.

The remaining eight patients in this group all had popliteal aneurysms and five of these patients were admitted with acute arterial occlusion of one type or another, secondary to the popliteal aneurysm. All five patients lost the extremity despite immediate surgical therapy. This consisted either of direct resection and grafting or thrombectomy with anticoagulants. Of the remaining three patients, all had early success in one form of treatment or another. One of these had a bypass fabric graft which became occluded at four months and following that had a moderately good benefit from a lumbar sympathectomy. Another had a thrombectomy distal to a popliteal aneurysm which had become suddenly occluded and is doing nicely under anticoagulant therapy. The remain-

ing patient had a bypass graft with complete restoration of circulation, but expired of carcinoma of the lung two months following his original surgery. At the time of his death, the circulatory status in the leg subjected to operation was good. The patient with an asymptomatic popliteal aneurysm, treated by an elective replacement graft and mentioned at the beginning of this section, has been followed for 16 months; the graft is holding up nicely, and there is no peripheral arterial insufficiency.

COMMENT.—The results in this small group of patients amply confirm what has been pointed out by others, namely, that the results of elective surgery in this particular group of patients are far better than the results which can be obtained by nonsurgical treatment of the patients, and also better than the results which follow emergency measures for these particular lesions.

Gifford, Hines and Janes,[5] for example, pointed out that of 21 popliteal aneurysms which had not been treated by surgery and were followed for five years or more, only five, or less than 25 percent, were without complications at the end of five years. On the other hand, 23 of the aneurysms in their series which were followed for an average of six years after surgical treatment showed no complication in any patient. Only two patients in our group have experienced difficulty following successful removal of the aneurysm, the one secondary to infection in a potentially infected case at the beginning, and the other due to an occluded bypass graft four months following surgery. The presence of arterial insufficiency in any form, particularly an acute thrombosis, markedly alters the eventual outcome of the surgery as evidenced by our own failures in five of the popliteal aneurysms. Inadequate distal runoff in the tibial vessels was an added factor in several of these patients, this complication usually being due to atherosclerotic occlusion in these vessels or to secondary thrombus following an acute occlusion in the aneurysm itself. Fabric replacements have done well in the treatment of these lesions as experienced by others.[6]

The only other comment noteworthy in this particular group of patients concerns the need to follow them closely for other vascular lesions. This has been pointed out many times before in that these particular patients are prone to have associated cardiovascular diseases and many of them have been shown to have other aneurysms involving either the aorta or the opposite popliteal artery, or situated elsewhere in the vascular tree. Two of our patients had bilateral popliteal aneurysms while one of these has an associated small abdominal aneurysm.

Aortic Aneurysms

Forty patients were operated on with varying types of problems related to aortic aneurysms. Of this group three patients were subjected to an exploratory operation without a resection, either because the lesion was too extensive or unrelated conditions required prior surgery. All of these patients expired at a later date and before resection of the aneurysm could be performed. Of the remainder, 15 patients were operated on because of rupture of the abdominal aortic aneurysm, seven had a resection as a semiemergency, and 15 had elective resections.

In the case of the ruptured aneurysm, one patient had an exploration with no resection because of involvement of the renal artery; this patient died three days later. Nine patients underwent resection and expired postoperatively, the majority dying of renal shutdown, whereas the remainder died of cardiovascular complications. From a review of the operative records, there was no apparent correlation between the amount of retroperitoneal bleeding and the survival of the patient. Renal shutdown was complete in some patients with minimal retroperitoneal bleeding, whereas some of the patients with the largest amount of retroperitoneal bleeding had no depression of renal function postoperatively. Five patients survived resection of the ruptured aneurysm. Only one patient in this group has died; this death occurred four months following surgery and was due to hypertension and advanced renal disease. The remaining four are living and well, although one patient was lost to follow-up at the end of nine months. The remainder have survived 16 months, five months, and three months, respectively.

The group of seven patients who required aortic surgery as a semiemergency procedure falls into a class where the mortality has been high. Only three survived resection, two of the patients now for over two years and the third for one and one-half years. These three are all in good condition with no apparent residual deficits and have normal capacity for work. One patient has evidence of superficial femoral artery occlusion on one side, but has not required further surgery. Of the four expirations, two were due to renal shut-

down, one to myocardial infarction, and the fourth to uncontrolled hemorrhage from a duodenal ulcer.

The remainder of this group of patients with aortic aneurysms had elective resections, one involving the aortic arch while the remaining 14 involved the terminal abdominal aorta. There were three postoperative deaths, two being directly due to failures in graft material, while the third resulted from a myocardial infarction at the completion of surgery in a patient with severe cardiac disease. There were three late deaths, one at 10 months of a recurrent aortic aneurysm and the other two at 14 months, death being due to unrelated causes. The remaining nine patients are all doing well as far as the surgery is concerned. The follow-up period extends from two months to four years.

Of the 20 patients who survived the immediate postoperative course, two had resection of the aneurysm without the necessity of a graft replacement. In the remainder there were 13 fabric graft replacements and five homograft replacements. There has been no concrete evidence of graft failure in any one of the fabric replacements. One patient had a bilateral amputation prior to his death 14 months following surgery, but it was noted at the time of operation that he had bilateral iliac artery arteriosclerosis and it is thought possible that the arterial insufficiency of the lower extremities was produced by rapid progression of this particular disease rather than failure of the graft itself. Likewise, there has been no evidence of secondary deterioration or other change in the five patients with homograft replacement with follow-up extending to four years. There were two early deaths caused directly by graft failures at a time when the original nylon material was being used which had to be heat-sealed. These grafts both ruptured producing secondary shock and subsequent renal shutdown during the early postoperative phase. Since changing over to Teflon or Dacron, however, in the 13 patients mentioned this complication has not arisen. Two patients have been noted during the follow-up period to have recurrent aortic aneurysms. One patient expired at 14 months following the original aortic surgery with a recurrent pelvic carcinoma; it was noted at the time of her death, however, that she had a recurrent aneurysm which by palpation involved the aorta proximal to the original homograft which was believed to be entirely normal. The second recurrent aneurysm was noted in a patient who expired 10 months following the original resection, and again the recurrent aneurysm occurred above the site of a fabric graft. In this instance, however, the recurrent aneurysm perforated and led to his subsequent demise.

Comment. — The most important observation to be made on this particular group of patients is that the percentage of ruptured aneurysms and aneurysms operated on as semiemergencies is much too high compared to that in the group of elective surgical procedures. Undoubtedly this is true simply because of the community from which this material was gathered and since these cases are consecutive in order of appearance. On the other hand, it directly reflects on the mortality rate which is considerably higher simply because of the tremendously increased risk in these two classifications of patients. Others have found a correspondingly high mortality rate in the group with ruptured aneurysm as evidenced by the report of Elliott, McKenzie and Chung,[7] who were able to save only nine of 24 patients subjected to exploration for ruptured aneurysm. They also directed attention to the gravity of the situation in so-called acute abdominal aneurysms. Other reports such as that of Dye,[8] who found a mortality rate of 7 per cent in 57 asymptomatic patients as compared with a mortality of 24 per cent in 39 patients with symptoms, point out the reflection of this group of patients upon the overall mortality rate. On the other hand, it is apparent from our patients and the reports of others that once these patients have survived the initial surgery, the prognosis is about as good as for the patient who survives an elective resection of an aortic aneurysm.

Perhaps the most important observation of all concerns the survival rate of patients having surgical therapy of abdominal aneurysms compared with the survival rates of patients who were treated medically for aneurysms. Sheranian, Edwards and Kirklin[9] pointed out a survival rate comparable with the figures of De Bakey and his associates of approximately 70 per cent survivors at the end of three years as compared to only 49 per cent survivors in Estes' group of medically treated patients at the end of three years. Certainly the lack of complications in late follow-up in all reported cases makes it all the more imperative that we reduce the number of patients coming to us with ruptured aneurysms or situations in which they have to be operated on as semiemergencies. It is apparent that early operation in the asymptomatic stage has the same importance in the field

of aneurysmal surgery as it does in the field of cancer surgery.

Although the follow-up figures in this series do not show the disadvantages of using homografts, there are innumerable reports in the present literature which point out the multitude of complications which are shown to be directly due to the use of homografts. As a result of these reports homografts were discontinued two and one-half years ago, to be replaced with Dacron or Teflon fabric grafts.[9,10]

Vasospastic Diseases

Four patients exhibiting intermittent peripheral arterial spasm were seen during the past four years and treated with lumbar sympathectomy. Preoperative arteriography showed no evidence of any localized arterial obstruction in any of the patients, even though one had actual gangrene of a toe. Lumbar sympathectomy was performed on the basis that they were exhibiting intermittent arterial spasm of the distal vessels. All four of the patients have had excellent results, three of them having primary arterial spastic diseases, while the fourth had an associated thrombophlebitis which was producing the arterial spasm. The latter patient was followed for two months with definite warming of the foot and cessation of the symptoms due to arterial spasm. The remaining three patients have been followed four months, 15 months, and one and one-half years respectively with no recurrence of the previous disease.

Occlusive Diseases

The remaining patients in this group of 154 cases all had arterial occlusive disease of one type or another, and the differentiation of the patients by their disease process is the only way in which one can come to any conclusion concerning the over-all results. In general, there are two types of occlusive diseases, the first with diffuse involvement of the terminal aorta and common and external iliac arteries, extending on down to the femoral and popliteal vessels. The second group has a much more localized disease process usually spoken of as segmental occlusion; in these instances various sites of involvement of the vascular tree may be completely occluded while the remainder of the vessels, either above or below this level, may be widely patent with no appreciable involvement by the disease process. The latter situation will be discussed first with a differentiation as to the level of the occlusion.

Aortoiliac Occlusions

There were 11 patients treated with varying degrees of obstruction involving either the terminal aorta or both iliac arteries. Eight patients in this group were considered as presenting examples of the Leriche syndrome while the remainder were patients with unilateral iliac artery occlusion. Two patients were subjected to exploration, but because of apparent involvement of renal arteries, no further surgery other than lumbar sympathectomy was attempted. There were five endarterectomies performed on the remaining nine patients, usually combined with lumbar sympathectomy. Two patients had bypass grafts from the aorta to the external iliac or common femoral arteries, while two other patients had resection of the occluded aortic bifurcation and replacement with a homograft. During the follow-up period, which has ranged from three months to four years with a majority of the patients in their second year, only one complication has occurred as regards any of the surgical procedures. This involved one of the homograft replacements performed four years ago; on the patient's follow-up examination at four years she had occlusion of either the distal limb on one side of the homograft or occlusion in the external iliac artery runoff. Mild claudication developed in this extremity, and she was advised to have another operation if the symptoms progress. In the remaining eight patients distal circulation has remained entirely patent, and all patients are living and well with normal capacity for their occupations.

COMMENT. — The one failure in this particular group is not unexpected, based on the experience of others.[10] Furthermore, this patient should have fairly excellent chances of success with a second operation if this should become necessary. The percentage of closures of arterial reconstructions in this portion of the body varies considerably depending upon the various authors. Crawford, De Bakey, Morris and Garrett[11] reported a minimal figure of 6.2 per cent late failures with a combination of methods, whereas Freeman and Nicholson[12] reported 24 per cent closures. The latter's report dealt only with thromboendarterectomy. Most authors believe from a study of their results that if occlusion has not occurred in the first two years, then chances of it occurring late are rather remote. Shepherd and Warren[13] also reported a moderately high rate of closures during the late phase, as 35.5 per cent of their patients leaving the hospital with patent segments had

closures taking place in the first year. Their report was also of interest in their comparison of mortality in their 40 patients with that of a group reported by Beckwith in which 22 of 49 patients died in a six year period. None of these 49 patients were operated on, whereas in Shepherd and Warren's series of operative cases numbering 40, only four patients died during this same period of time. There is little question that the results reported in all the papers along with our few results indicate that reconstruction operations for occlusions at this level give most satisfactory results and in all probability the procedure of endarterectomy has its highest incidence of permanent success in this area. In those few patients in whom endarterectomy is not feasible because of involvement of the media or adventitia by the occluding process, then a bypass graft gives the next possible best result.[11]

Superficial Femoral Occlusions

As has been pointed out repeatedly in the literature, one of the most important aspects in any type of grafting procedure on the arterial system is the demonstration of an adequate inflow and outflow system.[11] Rigid emphasis was placed on this demonstration in this particular series of patients, and as a result the number of patients in whom pure superficial femoral artery occlusion was demonstrated without occlusive disease elsewhere is small. The follow-up results, however, seem to demonstrate adequately the importance of this particular facet of arterial surgery.

Fourteen patients make up this group with five patients presenting an acute arterial insufficiency although they all had a preceding history of claudication. Three of these five patients had a distal thrombectomy beyond the site of superficial artery occlusion, in two of whom it was unsuccessful leading to subsequent amputation. The third patient had a combined sympathectomy along with the thrombectomy and has maintained adequate circulation for a period of two years following surgery. The remaining two patients in this group of acute arterial insufficiency had bypass common femoral to popliteal grafts with immediate restoration of distal circulation. These patients are now doing well at one and one-half and two years respectively.

There were nine patients with chronic obstruction who were shown by preoperative arteriograms to have adequate inflow and outflow systems. One patient had an endarterectomy nine months ago and has had an excellent result. The remaining eight patients all had bypass grafts, one of which was a homograft, inserted three and one-half years ago. These patients have been followed from four months to three and one-half years with one death in the group at nine months postoperatively due to myocardial infarction. At the time of completion of the follow-up, peripheral circulation had remained intact in all patients. One of the group operated on seven months ago shows decreasing oscillometric value, but still has palpable distal pulses. It is possible that in this one particular patient occlusion may occur in the near future.

Comment. — Although some authors report that 60 per cent of patients demonstrating occlusion at the level of the femoral-popliteal arteries will have distal runoff which is patent,[11] the results in the present series do not agree with this result. The 15 patients in this group represent only 37.5 per cent of the total group with atherosclerotic involvement at this particular level of occlusion. This may also explain why there has been only one patient in the long term follow-up who shows any sign of beginning occlusion of the graft. As pointed out, this patient still has palpable distal pulses, however. The reports of late patency again vary tremendously with the series reported and obviously with the type of procedure used. Whitman, Janes, Ivins and Johnson,[1] for example, report 70 per cent late patency using a Teflon prosthesis. Crawford and his associates[11] showed that late failure occurred in 52 per cent of their patients with homografts, 32 per cent with the braided nylon graft, and 11 per cent with the flexible knitted Dacron graft. Whether or not a bypass graft is used in preference to an endarterectomy seems to be primarily based upon the experience of the surgeon. It would seem expedient to conclude that if the lesion is localized to a short segment and is amenable to thromboendarterectomy, then this would be the preferable procedure. On the other hand, extensive occluded segments in the femoral area can be handled easily and with a relatively short operative procedure by using a bypass fabric graft. As mentioned previously, however, the ultimate patency, other things being equal, depends to a great extent upon the demonstration of an adequate inflow and outflow system in each patient.

Diffuse Atherosclerosis

Forty-two patients are left in this group for discussion, all having evidence of diffuse atherosclerotic involvement of the arterial system. Some

had a preponderance of disease in the iliofemoral segment, others in the femoral-popliteal portion, and the remainder in the tibial vessels. There were 10 patients in the first group, 25 in the femoral-popliteal group, and seven with distal sclerosis involving the tibial vessels. Diffuse arterial disease was demonstrated in all patients by means of arteriography. Forty-one lumbar sympathectomies were performed in this group, two patients having bilateral procedures. Two endarterectomies were accomplished, one being combined with an iliopopliteal bypass graft. The remaining procedure was a popliteal thrombectomy for an acute thrombosis proximal to the distal sclerosis. Six patients died in the immediate postoperative period, all because of some complication of the cardiorenal system. There were two late deaths, both cardiac in origin. Six patients in the entire group were diabetic, an incidence of 14 per cent, and only one of these was included in the group of deaths, namely one subjected to late exploration; death was due to myocardial infarction.

Surprisingly enough, the results were essentially the same no matter what the level of the major occlusion. Nineteen of the total number of patients had what was considered a good result from lumbar sympathectomy; two other patients with endarterectomy likewise had excellent response. From a numerical standpoint, exactly one half of each group of patients at the major level of occlusion had improvement by operative means while the remaining half had subsequent amputations or early expiration as noted. Three of the six diabetic patients, all of whom were a part of the femoral-popliteal group, had permanent improvement by operative means, one of which was an extensive femoral-popliteal endarterectomy. One of the diabetic patients, as noted previously, expired at 15 months following the first of a bilateral sympathectomy. Follow-up in all surviving patients ranged from three months to three and one-half years, with the majority of those subjected to sympathectomy observed over two years' time. It should be noted that all the failures in this group who survived the original operative procedure subsequently underwent amputation within one to four months.

COMMENT. Comparison of the report on this group of patients with other reports in the literature is somewhat misleading inasmuch as the operative procedure of sympathectomy was used in all patients with arterial insufficiency whose distal extremities still showed the slightest sign of viability. It was apparent in many of these patients that in all probability nothing would help the extremity, and a sympathectomy was used strictly as a remote possibility of aid. The more interesting conclusion would seem to be that one half of the total group can be helped and the level of occlusion does not necessarily preclude the value of the sympathectomy, for example, over its value at another level. In general it has been thought that patients with distal femoral artery occlusion and poor tibial runoffs, but with good collateral circulation, are the optimum patients for sympathectomy. Four of the patients, however, with iliac occlusion along with evidence of femoral arterial involvement, likewise had good results from sympathectomy. Also, three of the patients with distal tibial involvement alone had improvement with lumbar sympathectomy. The other interesting facet, as noted by many other authors, was the degree of improvement following the initial response to sympathectomy. This good result seems to be a lasting result as many of our patients undergoing sympathectomy have been followed over two years and there has been no apparent progression in the degree of claudication nor in the symptoms relating to the arterial insufficiency. Although the degree of claudication is not changed tremendously by sympathectomy, nevertheless, the patients seem to notice less discomfort in the extremities on exercise, and many are returned to gainful occupations. Edwards and Crane[14] in their survey of lumbar sympathectomy results five years after the operation sum up the picture of the diffuse arteriosclerotic patient well by concluding that there appear to be two types of these particular patients. One has a relatively localized arterial involvement of slow progression, and this responds extremely well to sympathectomy with a subsequent good life expectancy. The other patient has a diffuse arterial involvement, a rapid progression, does poorly after sympathectomy, and has a poor life expectancy.

Conclusion

Experience gained from treating 154 patients with varying types of arterial lesions during the past four years is presented. Many of the problems outlined seem to have fairly clear cut answers and the results are in line with those reported in much larger series throughout the literature. Suggestions are made to improve the over-all results

by certain operative procedures and methods of treatment during the initial phase which have a direct bearing on the ultimate outcome. The high percentage of ruptured aneurysms and other aneurysms operated on as semiemergencies is a reflection on vascular surgery as performed in a community hospital. The low mortality and extremely good prognosis obtained in the patient with an aneurysm on which operation is elective both serve as a plea for earlier diagnosis and earlier operation in this condition.

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Discussion

Dr. Richard G. Connar, Tampa: I have enjoyed Dr. Moody's paper, and I think he has done well in emphasizing some important factors that influence both early and late results in the field of vascular surgery. Although there have been numerous articles in the medical literature during the past few years concerning vascular surgery, relatively few authors have emphasized the potential complications which may and actually do occur both early and late. My own experience has amounted to approximately the same number of cases as Dr. Moody's series, but with a little different distribution. The largest group is concerned with diseases of the abdominal aorta and iliac arteries of which there are 41 aneurysms and 32 aortoiliac occlusions. Twenty-four of the aneurysms were nonemergencies and were resected electively with an operative mortality of 4 per cent. I have used modified hypothermia for these cases during the past two and one-half years, dropping the body temperature to 90 to 92 F. without precooling the patient. There appears to be less postoperative suppression of renal function on using this technique. Early in the series there were five homografts and two Tapp-Edwards nylon grafts used. In one of the latter, an iliac limb occluded two years later. Sanger-Taylor knitted Dacron grafts were used until 15 months ago, and two of this group had late thrombosis of the graft, one at 10 months and one at 15 months after operation. In both instances, an endarterectomy of the iliac arteries and partial resection of the graft with insertion of a new graft were necessary. Both of these grafts have functioned well for over a year now. As some of you may recall, these Sanger-Taylor Dacron grafts were not crimped, and this raises a possibility of kinking of the iliac limbs. De Bakey crimped Dacron grafts and woven crimped Teflon grafts have been used exclusively for the past 15 months with no late thromboses. The one death in this group was a result of renal failure, the patient dying seven days after operation. All of the fatalities with the ruptured and dissecting aneurysms resulted from renal failure with death varying from five to 20 days after operation. Because of this experience, I have elected not to operate on patients with ruptured aneurysms who are in shock and have been anuric for at least 12 hours before I see them. This decision has eliminated at least six patients who are not included in the accompanying table. Two patients also not included died en route to the operating room with ruptured aneurysms.

My experience has been limited with thoracic aneurysms. The one patient who survived is doing well four years after resection. The popliteal aneurysm group are all doing well with palpable distal pulses from six months to two and one-half years following surgery.

In my personal experience, the patient with the aortoiliac occlusive disease has been a much poorer operative risk than the patient with an aneurysm because of the extensiveness of his arteriosclerosis. Three of the five patients who died in this group of 32 did so as a result of the arteriosclerosis. There was one patient who survived a stroke five days after operation and in whom the homograft thrombosed one and one-half years after surgery. I believe strongly that a good endarterectomy gives better results than grafting. I have not had to employ endarterectomy distal to the proximal portion of the external iliac arteries in any of the patients in this group. In at least four instances, I had to go above the level of the renal arteries and have had good results in all of this group. There was one patient in this group in whom a graft, initially implanted elsewhere, had failed to function because of inadequate proximal endarterectomy of the abdominal aorta. A second grafting procedure approximately six weeks later brought excellent results for one year, but the graft thrombosed again, necessitating a third grafting procedure. Had I seen this patient originally, I would have preferred to perform an endarterectomy. I also think that it is important to re-establish hypogastric artery flow to get the best results, and one frequently does not do this with a graft.

It is my experience that if good distal pulses are present at the time of discharge from the hospital, late results will be good. My longest follow-up on an endarterectomy patient with extensive aortoiliac occlusion has been two and one-half years, and that patient continues to have good pulses in his feet. I have had one failure with an endarterectomy in a Leriche syndrome, the abdominal aorta thrombosing again one year later requiring amputation. I require aortography preoperatively on all these patients with occlusive disease, but rarely for aneurysm. Nevertheless, there was one patient who was operated on and was found to have diffuse disease of the abdominal aorta which negated the possibility of grafting or endarterectomy. This was approximately four years ago, and actually the patient's gluteal claudication is less today than it was prior to surgery. Like Dr. Moody's two cases, there has been no clinical evidence of progression of his disease.

My experience has also been similar to Dr. Moody's in patients with peripheral disease, in that I have not seen many patients with segmental occlusion of the superficial femoral artery. There have been two late thromboses of Teflon bypass grafts, both occurring approximately one year after operation. In both of these cases grafting was repeated with only fair results. Endarterectomy of the superficial femoral artery, in my experience, has given only fair results.

I have used only endarterectomy in the treatment of carotid artery thrombosis. The results with incomplete occlusion have been gratifying, those with complete occlusion equivocal.

I have had good late results in 12 of 14 patients with lumbar sympathectomy, but I would like to emphasize that all these patients had palpable femoral pulses preoperatively with evidence of distal small vessel disease. Lumbar sympathectomy has proved to be a good operation for small vessel disease, but if the common femoral artery is occluded, one should not expect very gratifying results and certainly in this group, thoracolumbar sympathectomy would be preferred.

Vascular Surgery

Aneurysm	Number	Operative Deaths	Per Cent Mortality
Abominal aorta (33 cases)			
Elective	24	1*	4
Dissecting or ruptured	6	4*	67
Nonresectable	3	1	33
Thoracic aorta	2	1	50
Popliteal artery	3	0	0
Carotid artery	1	0	0
Arteriovenous fistula (femoral)	2	0	0
Portacaval shunt	7	0	0
Splenorenal shunt	2	0	0
Arterial thrombosis			
Aortoiliac	32	5	16
Endarterectomy 20			
Graft 12**			
Femoral	18	0	0
Endarterectomy 12			
Bypass graft 6			
Carotid	10	0	0
Complete 8			
Incomplete 2			
Gunshot wound	3	0	0
Femoral artery, 2			
Axillary artery 1			
Embolectomy	11	40% successful	
Saddle 3			
Femoral 7			
Popliteal 1			
Sympathectomy	15	1	7
Lumbar 14			
Thoracolumbar 1			
Ten of 12 patients with palpable femoral pulses improved			

*Deaths due to postoperative renal failure. Complications: 1 B-K amputation. Late deaths: 1 aortoduodenal fistula; 1 pulmonary tuberculosis.

**Five homografts; 6 plastic tube grafts.

DR. JOHN R. EMLET, Pensacola: I would like to congratulate Dr. Moody on his precise presentation of this varied group of consecutively treated cases of vascular lesions and on the results he has obtained. As I listened to this paper, I was reminded of the story I heard years ago about a doctor in the mountains of North Carolina. He served his small community well, although he had none of the laboratory aids we have now. Apparently he knew the art of medicine if not the science of medicine. One of his patients came in expressing considerable concern about his heart. Methodically the doctor examined him and then after some deliberation he took the patient by the arm and said, "Joe, don't you worry; this heart of yours will last you as long as you live." Joe left the office reassured and satisfied.

If we look back 10 years or so, we will recall we had then no good definitive treatment for aneurysms or segmental occlusive vascular lesions. I would like to echo Dr. Moody's request that we be more alert to the early recognition of aneurysms, but in addition we be more concerned about the patient who has early signs of peripheral vascular occlusion and consider his evaluation for definitive treatment before marked ischemia, secondary major thrombosis, or frank gangrene occurs.

To be more specific in this discussion with regard to the various groups Dr. Moody has outlined, we have been fortunate in our own series of patients with vascular injuries. All but two of these have involved either the iliac or femoral artery and have been in younger patients. This group has been treated with insertion of either a nylon or Teflon graft and usually ligation of the concommitant vein. The late results have been good, and the only residuals have been due to associated femoral nerve injury. Up to three years there has been no evidence of calcification in the grafts by x-ray.

As to the matter of emboli, I heartily concur with the recommendation of prolonged anticoagulant therapy in this group. I can recall one patient who had emboli first in one leg and then the other and who was successfully treated. He was maintained on anticoagulants, but more than one year later he had a massive aortic saddle embolus and died. We learned later that the anticoagulants had been discontinued just one week before the fatal embolus occurred.

Grouping together the patients with aneurysm and arterial occlusive disease, our late results have been better in the patients with aneurysm. We still believe there is a place for sympathectomy in the patients with diffuse occlusive disease that is not too far advanced, but think that only about 30 per cent of this group are permanently benefited. The better results in aneurysm probably stem from the process being a more localized one and the tendency in all of these patients to develop some increase in collateral circulation about the aneurysm.

Time permitting, I would like to show two slides illustrating that even in the elderly patient definitive treatment can be considered. This is a 79 year old white man who was seen with a large iliofemoral aneurysm. He had been bedridden for two months, was in constant pain, and held the left thigh in a fixed position of flexion. The involved leg measured about twice the size of the other from obstruction of the venous return due to the size and position of the aneurysm beneath the inguinal ligament. The aneurysm was resected and replaced with a 10 inch Teflon graft. The patient is now able to be up and about.

Ophthalmological Approach to the Problem of Retarded Readers Among Elementary School Children

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Often the ophthalmologist is confronted with a child of elementary school age who is falling behind his peers in reading progress. Likely as not, he or she has been examined by a psychologist or child psychiatrist and perhaps even treated by one for several months. The intelligence quotient is reported to be normal or above normal, and the school grades in subjects other than reading may substantiate this rating. The child has usually been brought to the ophthalmologist by the parents, who optimistically hope that a need for glasses will be discovered and their child's reading problems will be solved and eliminated. In nearly every instance a routine thorough eye examination will reveal normal vision, no ocular pathology, no significant refractive error and good muscle balance. The parents are usually told that the child's eyes are normal and that his or her problem in an educative one. The child returns to school and continues to read poorly.

There are many nonocular factors that influence a normal child's ability to read, such as stimulation at home, availability of proper reading materials, good teaching methods in school and emotional problems. It is not uncommon, however, to find in a family of good readers one child who has a reading problem; or again, a child who has had every proper encouragement and help may have trouble with reading. Often psychological or psychiatric counseling and treatment fail to help, and at times special tutoring is inadequate. Some children are taken repeatedly to an ophthalmologist in search of an answer to this problem.

This report deals with some discoveries I have made in attempting to find an ophthalmologic basis for the problem of the poor reader. It represents the findings on 100 children, 60 boys and 40 girls, whose chief complaint was retarded reading. All had normal intelligence as rated by their school teacher, and all were making average or above average progress in other school subjects. All were between the ages of six and 12. No child had a significant refractive error in either eye (less than 1.00 diopter sphere or 0.50 diopter cylinder), nor less than normal visual acuity in both eyes (20/30 for first grade; 20/25 for second and third grades and 20/20 for fourth, fifth and sixth grades), nor any ocular pathology, including strabismus.

A thorough questioning of the child and parents often revealed other symptoms that are characteristic of the retarded reader, such as:

- Skipping words, especially prepositions and articles
- Losing place
- Reversal of words such as "saw" for "was"
- Copying incorrectly from blackboard
- Failure to complete assigned work in required time
- Mirror writing (in first or second grade)
- Difficulty focusing eyes from one thing to another
- Headaches
- Poor concentration
- Poor retention of information that is read by the child

Well over half these 100 children had moderate to severe behavior problems in school. These included:

- Nervousness — "can't sit still" (very common symptom)
- Disturbing other children
- Daydreaming
- Talking too much
- Not taking directions well
- Difficulty getting along with other children

The incidence of left-handedness was about twice that of the general population, and the incidence of lack of definite handedness was also

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more than average. All these findings have been noted and recorded by others who have studied this problem.

A recent survey of the problem from its various aspects was reported by Goldberg.[1] The need for early detection and treatment was stressed. In a study of 2,400 school children, Eames[2] found the incidence of brain damage higher among the poor readers than the good readers. Also the poor readers showed a slightly higher incidence of hypermetropia over 1.0 diopter, exophoria over 6 prism diopters at the reading distance, fusional difficulties, and lateral dominance variations other than right-handed–right-eyed. Another investigator found crossed dominance to be present in 20 per cent of a group of school children classified as good readers and in 40 per cent of a group of poor readers.[3] An inability to maintain binocular fixation at the reading distance was observed as one cause of retarded reading by White and Wahlgren.[4]

Analysis of Series

Each of the 100 children in this study demonstrated one, two or all three of the following findings:

1. Alternating intermittent macular suppression
2. Crossed dominance
3. Convergence insufficiency

Alternating intermittent macular suppression is manifested by the fading and reappearing of parts of macular targets on slides in the major amblyoscope. Parts of the picture come and go as the child continues to watch it.

Crossed dominance is defined as the presence of a dominant eye on the side opposite the dominant hand, either right-handed and left-eyed, or left-handed and right-eyed. This may be tested by the simple procedure of finding the sighting eye or by the more extensive test in the Keystone series.

Convergence insufficiency has herein been considered in stricter terms than those usually accepted. By convergence insufficiency is meant the inability of the child to bring his convergence to at least 5 cm. from his nose and maintain it for several seconds.

Crossed dominance was observed in 32 children. Alternating intermittent macular suppression was present in 92 of the children. Convergence insufficiency was noted in 68 children. These figures indicate that some children had more than one of the three findings, and indeed, 72 had two abnormalities and 16 had all three.

Crossed dominance has been reported to occur in 20 per cent of the general population. In a random survey of 92 school children that my technician and I conducted, alternating intermittent macular suppression was present in some degree in 60 per cent and of moderate to pronounced degree in 40 per cent, as compared to its incidence of 92 per cent in the present study. Convergence insufficiency was present in 23 per cent of the 92 school children, as compared to 68 per cent in the present series.

Treatment

Convergence insufficiency is treated with the usual exercises of stimulation of the near point vergence movements, of controlled fixation and diplopia exercises at near, and of bar reading.

Crossed dominance is treated by constant and prolonged occlusion of the currently dominant eye in order to switch dominance to the eye on the side of the dominant hand. This process requires from three to 12 months. When a mixed hand dominance is present, the eye on the side opposite that with which the child chooses to write is occluded.

Alternating intermittent macular suppression is treated by constant occlusion of the nondominant eye, or the eye desired to be made nondominant, and fusional training on a major amblyoscope. It usually takes at least three months to overcome the suppression. In some cases in the series when a lapse in treatment occurred, the suppression reappeared, but responded rather quickly to reinstituted treatment.

The behavior problems also require treatment. Whenever possible, we have tried to uncover the causes of trouble and help parents correct them. Tranquilizers (Compazine Spansules 10 or 15 mg. each morning) were prescribed for 40 of the 100 children.

Whenever a child was as much as one year behind in his reading level, special tutoring was recommended.

It is interesting to speculate on the probable outcome of untreated cases. It is certain that some persons retain this suppression all their life because often we find that the child's mother will relate her story of childhood reading problems that duplicate those of her child now under treatment. When tested, these mothers exhibit the typical findings. They often tell us that they

have never enjoyed reading and now read little except the daily newspaper.

Results

The minimum follow-up period on these 100 children has not yet been long enough to permit statements of fact about lasting results, but some effects have already become apparent to us:

1. The great majority of these children improved their school grades within the first six weeks of treatment.
2. Whenever the child did not successfully wear the occlusion, improvement was slight or absent.
3. Many school teachers telephoned to report dramatic changes in the progress and behavior of a child under treatment. Often reading ability improved within a few days while the patch was worn. In several instances we had the child omit the patch for a few days, then wear it again. Teachers and parents both noticed a concomitant change in the ease of reading on the part of the child.

It is proper to question the validity of these explanations of retarded reading and the interpretation of the results. The very act of focusing attention on the problem may have served as a stimulus on the part of the child to try harder in his school work. The use of tranquilizers alone may be helpful; we have not investigated this possibility fully.

An attempt was made to find a rapid screening procedure that would indicate which children in a given school class had these eye and reading problems. We screened 92 children; 45 in the fifth grade and 47 in the third grade. The near point of convergence was measured, a screen and cover test was made to eliminate tropias and large phorias, and finally, a rapid estimation of suppression was made on the major amblyoscope. Suppression was graded 1, 2, or 3 plus. The children were then listed in high, average or low reading groups, and the findings were compared. There was a complete lack of correlation between the degree of suppression and the reading group level.

Conclusion

The problem of the retarded reader is not wholly answered by the findings in this study, but at least some progress has been made. As a result, some children have been helped to develop better reading skills that should bring rewards in pleasure and achievement in their future.

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Discussion

Dr. Marion W. Hester, Lakeland: It is generally conceded that inadequate reading ability is responsible for the majority of school failures on all grade levels. If one accepts this hypothesis, it follows that it is proper to give a great deal of attention to creating reading skills in the earlier grades of school.

Dr. Benton has suggested some eye conditions which can contribute to a child's poor reading ability. With some of these mentioned conditions, it would be rather difficult to prove that they are the main cause of the child's reading difficulty. As Dr. Benton states, "The very act of focusing attention on the problem may have served as a stimulus on the part of the child to try harder in his school work."

It has been found that by giving attention to a child's reading problem with proper materials, guidance and practice, almost any child's reading ability can be vastly improved. I would like to recommend for your consideration some materials designed for this purpose.

"Practice Readers" by the Webster Publishing Company consists of books for various grade levels. These contain scientifically constructed and highly interesting exercises for diagnosis and effective instruction to improve seven different specific skills in study reading. These include comprehension of (1) direct details, (2) implied details, (3) meaning of the whole, and (4) correctness of statements in relation to the selection.

"Reading Skilltexts" for various levels by the Charles E. Merrill Company of Columbus, Ohio uses five reading skills: (1) understanding ideas, (2) interpreting ideas, (3) organizing ideas, (4) understanding word meanings, and (5) studying words. This company claims that intensive work with "Reading Skilltexts" the first few weeks of school will make pupils proficient in the reading skills necessary to achieve success throughout the school year. I have found this to be true in many instances.

The Reader's Digest Association also publishes "Reading Skill Builder Books" for children at different levels. These are attractive and interesting to children and improve reading ability in much the same manner as do the other described reading skill builders

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Common Foot Problems and Their Treatment

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The treatment of common foot problems has been seriously neglected by all medical schools throughout the country. Unfortunately, more and more emphasis is being placed on major surgical procedures than on minor procedures such as painful feet, and yet there are as many people having trouble with them as with their eyes. One does not have to look very far to notice the number of people in our modern civilization who are wearing glasses.

The lack of interest in the treatment of foot problems probably originates from the inadequate training of the medical student so that he has no interest or very little understanding of what constitutes a good problem and what is the treatment of this problem.

Physiology of Walking

Although all of us walk a good part of each day of our life, the mechanics of walking are not commonly understood any more than the average physician understands the true mechanism of respiration, in spite of the fact that under ordinary circumstances breathing is done 10 to 20 times every minute of his life.

When a person walks, the first part of the foot to strike the ground is the soft tissue on the plantar surface of the os calcis (fig. 1A). As the weight comes forward, the weight is then transferred to the metatarsal area of the forefoot (fig. 1B).

At this stage of walking, the foot is in a minimal amount of supination. As the weight is transmitted to the front portion of the foot, it is then rapidly transmitted across the transverse arch to the head of the first metatarsal (fig. 2).

When the entire metatarsal area is in contact with the ground, the weight distribution in this area is in the relationship as shown in figure 3. The first metatarsal head carries two sixths of the total body weight while each of the other four metatarsal heads carries one sixth of the total body weight. This is true under normal weight distribution when there are no displacements of the metatarsal heads.

As the weight comes forward, the propulsion power in walking is exerted by the large toe. It is the propulsion power that gives us the spring in walking. This is produced by the forced plantar flexion of the large toe.

It is a lack of understanding of this propulsion power of the large toe that leads to many types of bunion operations that are harmful. Any type of operation of the large toe area that interferes with the walking mechanism of the large toe contributes a surgical disability to the patient. For this reason, resection of the head of the first metatarsal to shorten it, such as is done in the Mayo operation, or the removal of the proximal half of the proximal phalanx of the large toe, such as is performed in the Keller operation, produces impairment in propulsion power and therefore a loss of the spring of walking. There is no question that under certain circumstances the Keller operation is definitely indicated, and that is when a hallux rigidus exists.

A great deal of research work has been done on the amount of weight that is borne on the metatarsal head under normal cirumstances. This is subject to a great deal of controversy, but to the best of my knowledge, as described previously, the distribution of weight is in the ratio of 21111, the greatest portion of the weight being on the first metatarsal head. Very frequently a falling of the transverse arch produces pain and discomfort to the patient because of abnormal weight bearing, and in some instances there is actual pinching of the intradigital nerve. There is a secondary involvement of the skin with callous formation as a result of abnormal weight bearing. The simple inspection of the plantar surface of the foot shows whether or not abnormal weight bearing is present, and nature shows us exactly where the abnormal weight bearing is. When the person has a fallen transverse arch, the distribution of weight may shift considerably. For example, the weight bearing may be in the relationship

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of 12210 with the second and third metatarsal heads carrying two sixths of the total body weight on each head; therefore, two thirds of the body weight is being carried on the second and third metatarsal heads (fig. 4). A callus rapidly forms in this area.

Women's Footwear

It is common knowledge that more women have trouble with their feet than men. Not very long ago a colleague of mine asked me about how many bunion operations I had performed on male patients in the last five years. I was somewhat embarrassed when I realized that I could not recall a male patient who had had a bunion operation, but I could recall dozens and dozens of women patients upon whom I had performed bunion operations in the last five years. There is a reason for this difference.

The present style of women's footwear has a very high heel somewhere between 3 and 4 inches in height with pronounced pointed toes. When a woman gets on high heels, most of her body weight is transmitted to the metatarsal head (fig. 5), instead of being primarily borne on the os calcis area. In addition to this body weight being in an abnormal location of the foot, the toes and the front portion of the foot are jammed into a wedge-shaped pointed toe of the shoe. The large toe because of its size has seniority, and therefore occupies the medial half of the toe of the shoe. The other four toes have to be squeezed and overlap one another as best they can, and invariably the fifth toe develops calluses, becomes distorted in shape, and overlaps the fourth toe (fig. 6). The second, third and fourth toes overlap and squeeze one another into the most grotesque disfigurations. It must be accepted by the treating physician that he is not going to change women's styles, and therefore he must go along and do the best he can with the present styling of women's shoes.

Paraphernalia for Foot Examination

If one is going to treat certain foot problems, he must by necessity have certain equipment. Since most of the foot problems start with improper shoes, one must have a measuring device to determine the length and width of a properly fitting shoe. The one device which has been most suitable in my experience is called the Brannock Device, which is used by many shoe salesmen. This gives the heel to ball and heel to toe measurement, and also the width of the foot. The

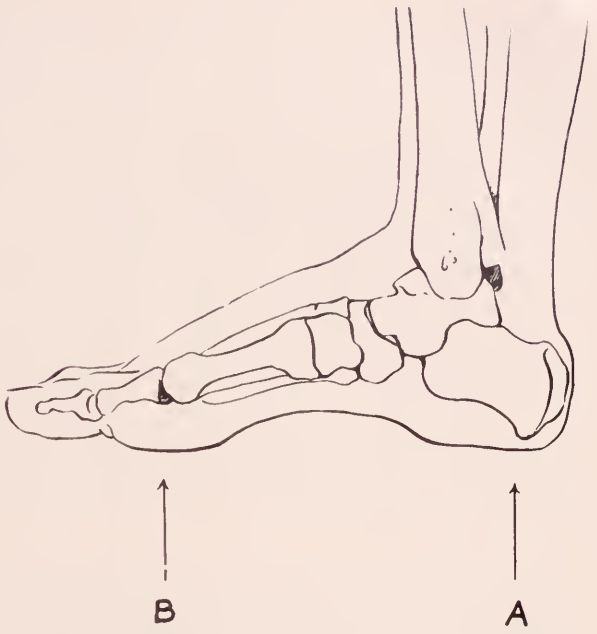


Fig. 1. — Schematic lateral view of the foot. A. Soft tissues over the os calcis that, in walking, first come in contact with the ground. B. Metatarsal area which comes in contact with the ground when the weight is shifted to the forefoot.

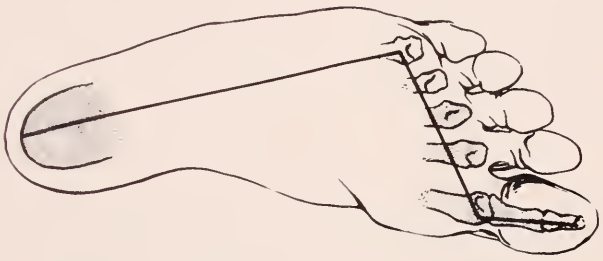


Fig. 2. — Plantar surface of foot showing the most important points of ground contact in walking. After the heel strikes the ground and the weight is shifted forward, the weight is then brought to bear on the head of the fifth metatarsal. From there the weight is shifted to the head of the first metatarsal. The push-off power or spring in the step is produced by the plantar flexion of the large toe.

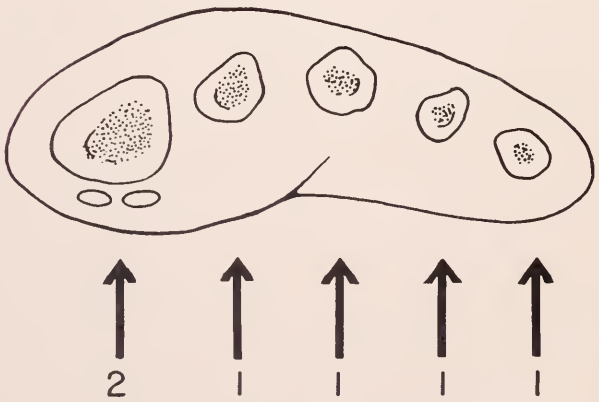


Fig. 3. — The normal weight distribution to the metatarsal area is shown on this drawing. One third of the total weight is borne by the first metatarsal head.

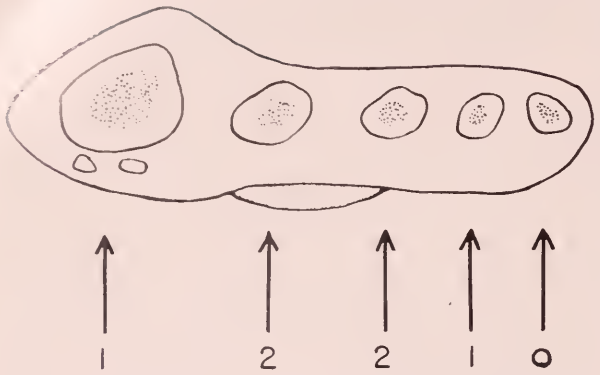


Fig. 4. — Abnormal weight bearing causes the greatest portion of the weight to be carried on the heads of the second and third metatarsals. A resulting callus occurs in this area, illustrated by the shaded part in the drawing.



Fig. 5. — The present style in women's shoes throws the majority of the total body weight on the metatarsal heads. This is an area which was never intended by nature to carry all this weight. It causes a breakdown of the metatarsal arch.



Fig. 6. — The pointed toes of modern women's footwear pinch the toes together, producing grotesque deformities and many abnormal pressure points.

most important measurement is the heel to ball measurement. This is the essential part of the weight-bearing portion of the foot, and in persons who have long or short toes the over-all measurement may vary considerably from the heel to ball measurement. When there is a discrepancy between the two, the heel to ball measurement is the one of critical importance and this is the size shoe that the patient should wear. Invariably, especially in women, the shoes are much narrower than the measurement on the Brannock Device. Here it requires the judgment and skill of a Socrates to inform a woman that she should wear a wider shoe, and fortunate is the doctor who has the "know-how" to convince women of this fact.

Ability to get weight-bearing foot imprints must be available in order to determine points of excessive pressure on the plantar surface, and also the contour of the longitudinal arches. I have tried many methods. The device which I am using at the present time is the one made by Scholl's Manufacturing Company. It has a sheet of paper with which an inking pad comes in contact. Over this there is a rubber sheet upon which the patient puts his foot. The patient stands on this rubber-covered pad, and this in turn transmits an imprint on the underlying paper. It shows the longitudinal arches and from the intensity of the inking on the pad one can determine where the points of maximum pressure are. This pedigraph is shown in figure 7.

If one does not desire to use this pad, other methods are available. A solution made of tincture of ferric chloride, 50 per cent, alcohol, 45 per cent, and glycerin, 5 per cent, can be put into a 2 ounce bottle and applied on the plantar surface of the foot with a 1 inch brush. The patient then steps on plain white paper. This method leaves an orange type imprint on the white paper which is permanent. It has one disadvantage, however, that tincture of ferric chloride does not come off with soap and water and has to be removed by alcohol. Another method which I have used for some time is the use of orange litmus type paper which is made by the Kleistone Rubber Company of Warren, R. I. It requires the application of a saturated solution of sodium bicarbonate to the plantar surface of the foot with a 1 inch brush. The patient then steps on the litmus paper and this leaves a permanent imprint. The use of a teaspoon of baking soda in a 4 ounce bottle of plain water is all that is neccessary, and this should be shaken each time before use in order to get the solution

in a saturated state. It leaves no staining on the plantar surface of the foot that has to be removed.

Many foot problems require instructions on how to do foot exercises in order to strengthen the intrinsic muscles of the foot. It is very time-consuming for the attending doctor to instruct the patient how to do the foot exercises, and very frequently half of them are forgotten by the patient before he gets home and some of the others are not done properly when they are executed. A number of years ago the Walk-Over Shoe Company put out a very fine booklet with the instructions on foot exercises and has been kind enough to send me a supply over the years, with a nominal charge. A booklet is given to the patient when indicated. Further discussion will be given later as to the use and indications for foot exercises.



Fig. 7. — Scholl's pedigraph. This ingenious device uses the principle of an inking pad without soiling the foot. Abnormal pressure areas appear as darker spots. This is an excellent method of taking foot imprints.



Fig. 8. — Dennis-Browne splint with eversion of the feet, used for children who toe in. This splint with the attached shoes is used during the child's sleeping periods.



Fig. 9. — Dennis-Browne splint with inversion of the feet, used for children who toe out. This splint with attached shoes is used during the child's sleeping periods.

Children's Foot Problems

Practically all foot deformities in infants can be corrected if treated early. Clubfoot and metatarsus primus varus should be treated as soon as diagnosed, within a few days after birth. All clubfeet are best treated on diagnosis. Experience shows that the earlier the treatment is instituted the more rapidly will the recovery take place and the end results are far better. Neglected clubfeet sometimes lead to complications and future surgical measures which are usually avoidable. The exact treatment of these conditions is beyond the scope of this article.

A common problem in children is the toeing in of one or both extremities. This is invariably due to muscle imbalance. The treatment is quite simple. The parents are instructed to rotate the feet externally 25 times after each nap and the first thing in the morning when the child awakens. In cases that are persistent the use of the Dennis-Browne splints (fig. 8) with a cross bar and the attached shoes is very useful. The affected foot or feet are treated by gradual external rotation of the ratchet on the brace so that the foot is held in progressive external rotation. Usually in a matter of several months this deformity can be easily corrected with no residual bad results.

When the child is up walking, it is important that he wear a rigid shank shoe and have a three-sixteenths inch wedge on the outer border of the sole so that in walking the foot will be constantly turned outward by the wedge and the superimposed body weight.

Toeing out presents another problem. It is important that all children who have a toeing out deformity, especially infants, have a roentgenogram taken of the hips in both the anteroposterior and frog position to rule out the possibility of a dislocation or a subluxation of the hip. It this exists, it must be treated immediately; otherwise, further difficulties arise with the formation of the acetabulum.

Everyone is acquainted with the fact that the physical findings of a congenital dislocation of a hip are easily recognized if one simply remembers

that the condition can exist. The following list presents the pertinent physical findings:

1. The leg is shorter and in external rotation on the affected side.
2. The groin crease and the gluteal crease on the affected side are higher than on the unaffected side.
3. If the knees are flexed and the feet are placed flat on the examining table, the knee on the affected side is lower than the one on the unaffected side because of the posterior displacement of the head of the femur.
4. External rotation is restricted on the affected side compared to the unaffected side.

If no congenital hip dislocation or dysplasia of the hip exists, then the condition is due to muscle imbalance. The parents are instructed to turn the feet in 25 times, three to four times a day. In cases that are moderate to severe in nature, the patients should be treated by the use of Dennis-Browne splints but with the feet turned in inversion (fig. 9).

When these children are up walking they should be fitted with high shoes with a rigid shank, and although it may seem paradoxical, the three-sixteenths inch wedge should be on the inner border of the soles so that in walking there is a constant dynamic force that turns the foot in, into the corrected position.

Another complication that one sees in children is the adduction deformities of the large toe or the hallux primus varus. In cases that are seen in infancy it is best that they be manipulated and placed in a plaster cast extending from the tip of the toes to the groin with the knee at right angle, and the ankle at right angle, with the wide abduction of the forefoot. When the correction has been attained, or if the child has a mild adduction of the large toe, then the use of pigeon toe shoes is advisable. This type of shoe causes an abduction of the forefoot and also has a wedge of three-sixteenths of an inch on the outer border of the sole.

Most children's problems can be solved readily if recognized and treated early. It is a common mistake for the parents and the doctor to say that the child will outgrow the deformity.

A common, unrecognized fact is that all children have flat feet until they are old enough to be up and about. Until then they have not had an opportunity of wearing down the fat pad that nature has placed on the plantar surface. Invariably a mother will bring a child in and state that the child's feet are flat and that her husband has flat feet and she desires to have something done about it. We know that children with this problem will get well spontaneously, by the use of a small longitudinal arch of both feet. This will quiet the mother, will help in the correction of the problem and in the final analysis will cover the doctor with, perhaps, undeserved glory.

Corns and Calluses

A corn or callus is the result of abnormal weight bearing. The callus itself is a thickening of the epidermis, and it is my belief that a corn is simply the further progression of this callous formation with a thickened skin and epidermis that runs deeper into the tissues and has what appears to be a core.

In the treatment of calluses and corns the usual problem is tight shoes, or abnormal weight bearing, such as in the metatarsal area. This must be first corrected; otherwise, the condition will recur regardless of what other form of treatment is rendered.

It has been found that the local application of 10 per cent salicylic acid in flexible collodion every night to the callus is very beneficial in its removal. The following evening the foot should be soaked in hot water for about 15 minutes. Some of the callus will come off spontaneously after each soaking.

The use of a cuticle cutter, such as used in trimming the finger cuticle, or a very sharp thin knife or a razor blade is advantageous in trimming down the callus, if it is thick.

Under this regimen calluses and corns can be taken care of.

Fallen Arches

Everyone recognizes the fact that there are two arches in the foot, a longitudinal and a transverse arch.

It is axiomatic to state that a painless flat foot should be left alone. It is only when the flat foot gives rise to symptoms that it should be treated.

The usual etiological causes for flat feet are the following:

1. Obesity.
2. Poor walking position with the foot in external rotation.

3. Occupations in which the patient must be on his feet for long periods of time, such as those of postman, policeman or waiter.
4. Cement pavement upon which persons have to stand for long periods of time during their occupations, such as salesmen and those who work at machines.

Sometimes there is an element of simple weakness of the longitudinal structures, and the calcaneovalgus position of the heel is a very common etiological cause for flat feet, especially in young people.

The treatment of the longitudinal foot problem depends on the degree of the pathologic change.

If the etiological cause is overweight, this must be corrected. If the etiological cause is occupation, it is not always easy to change the occupation, and one will have to take steps to help the feet counteract this occupational stress.

If the heel is in a calcaneovalgus position, the use of a Thomas heel, which is about half an inch longer on the medial border than the lateral border, is advantageous. The use of a wedge on the medial border of the heel about one-eighth or three-sixteenths of an inch will get the calcaneovalgus position into a more normal one.

The use of longitudinal pads is important. They should be placed so as to relieve the patient of his discomfort and they should be built up only to the extent that is necessary to relieve the symptoms. The height of the pad is not as important as the symptomatology. Commercial pads are available that are made out of sponge rubber and leather and these are the ones that I recommend. They can be purchased through many supply houses throughout the country, but the ones that I have used for years are made by the Kleistone Rubber Company.

Construction of the shoe is important. Persons who are overweight and who break down shoes readily should have special shoes with a rigid shank, giving them rigidity. A long counter, which is a fiber type of reinforcement between the leather layers on the inner or medial border of the shoe, gives additional support, and the patient cannot break down the shoe readily. The breaking down happens all too frequently in overweight persons, especially those of advanced ages.

Exercises are important. This is especially true in young people. The booklet which has been recommended, published by the Walk-Over Shoe Company, serves this purpose very well. The exercises should be done every night before going to bed, for a period varying from five to 10 minutes depending on the degree of the pathologic change and the cooperation of the patient. The three principal exercises which are recommended are:

1. The coming up on the toes on the count of the one, the coming down on the lateral aspect of the foot and curling the toes in on the count of two and the placing of the foot in the normal position at the count of three. This is done rhythmically 25 to 30 times each evening.
2. Walking on the lateral aspect of both soles with the toes curled under. This places the heel in a marked calcaneovarus position. It is recommended that the patient walk the length of the bedroom, 15 times each evening.
3. Improvement of the function of the short flexors and the plantar structures of the foot by exercising the toes in the flexion position over the end of a large book. The exercise of trying to pick up a handkerchief or marbles or a pencil with the bare feet. This is achieved quite readily in children, but is quite difficult for older persons to do.

The treatment of the fallen transverse arch is not too difficult when one realizes, as stated, that the distribution of the weight over the metatarsal heads is most important. Nature has been very kind in producing a callus where there is too much weight, and if the examining doctor will simply examine the bottom of the foot, he can see where the abnormal weight is being borne. The callus must be treated locally by the use of 10 per cent salicylic acid in flexible collodion and by trimming the calluses each evening, as stated previously. A properly fitting pad should then be inserted into the shoe under the metatarsal region. Insertion cannot be done by guess work. It must be done accurately. The measurement is made from the back of the callus to the back of the heel, and then this exact measurement is placed into the shoe. The metatarsal pad is then inserted accurately in this area, usually starting with the low metatarsal pad. The pad is increased in size until the patient is free of symptoms. Usually the pad will feel strange for a matter of a week

or 30 days. The patient should be so informed. If his symptoms are not relieved, then a larger pad should be placed in the shoe until he is comfortable. Once the patient is comfortable, no further change in the pad should be made.

In my opinion one is better off with a pad that is glued into the shoe and stays in a fixed position rather than with one that can be moved from one shoe to the other, and never in quite the same position.

When a metatarsal pad is used, it is necessary that the patient have a closed heel and closed toe shoe; otherwise, it probably will be unsuccessful. It is very difficult to put a metatarsal pad in a shoe and have it work successfully if the shoe has a high heel with an open toe. For this reason when metatarsal pads are inserted, it is best that the patient wear a Cuban heel or a nurse's shoe with a heel that is not higher than 1 inch or 1¼ inches in height.

Painful Heels

Very commonly patients complain of pain and discomfort in the heel. Surprisingly few have a calcaneal spur. This can be best diagnosed by a lateral roentgenogram. If the calcaneal spur is present, it is sometimes necessary to remove it surgically if conservative management has failed. The conservative management will be described shortly.

Many persons have a bursitis over the os calcis that gives them this pain, and it is important that the pressure be relieved from this area. Some medication should be given by mouth to reduce the inflammation in this area, which some believe represents pathologic change similar to that observed about rheumatoid joints.

The insertion of heel pads with a circular opening in the center or the use of half moon heel pads so that the pressure is sustained on the periphery rather than on the center is very worth while. The use of different size heels in several pairs of shoes is worth trying. The patient should have one pair of shoes with heels one-half inch higher than the standard height. On alternating days the shoes are changed with the regular shoes so that the weight is never quite in the same place in the heel on two consecutive days. If the patient feels better with one pair than the other, then he should wear the shoe with the heel height that gives him the most relief.

The soaking of the feet each night in hot water with a level tablespoon of Epsom salts to a gallon of water seems to give relief to many of these patients. The application of analgesic balm locally after the hot soaks is recommended.

Some form of salicylate seems to help these patients, and the one that I use is commercially prepared Pabalate. Other forms of salicylate therapy, I am sure, are equally as good. Under this regimen the majority of the patients are cured of their painful heels.

In persons who have calcaneal spurs, the removal of the spur surgically is indicated only after conservative management has failed. It is a well recognized surgical fact that if the pressure is kept off the spur for a while, nature will lay down a very thick fibrous mass around this calcaneal spur and in many cases the patient becomes symptom-free.

It is symptomatology and not the roentgen findings that determine whether or not a patient should have an operation.

Foot Problems That Require Surgical Correction

The surgical correction of certain foot problems should be delegated only to a surgeon who is trained in this particular field. Suffice it to state that such conditions as hammer toes, bunions, bunionettes, and hallux rigidus are definite surgical entities and can be cured successfully by surgical measures. The details on the surgical procedures will not be discussed in this paper as they are beyond the scope of this discussion. They take one far afield from the material which is available or should be used by one who has not been trained in this particular form of orthopedic surgery. The erroneous belief of many of the laity that bunion operations are not successful or beneficial is not justified. One cannot help but think that in some instances their reaction is correct, because in the past some of the bunion operations were harmful. They destroyed the relationship of weight bearing to the metatarsal arch and the propulsion power of the large toe as described previously in this article.

Suffice it to say that everyone should recognize the fact that surgical correction of foot problems can be made very skillfully and with excellent results. Should a general practitioner be presented with such a problem, then his only decision should be one of referral. The patient should be sent to a surgeon who does this particular type of work. I am sure that in every community there are men who are capable of performing this type of surgery very skillfully.

104 South Michigan Boulevard.

ABSTRACTS

The Use of Radioisotopes in the Clinical Study of Renal Function. By Julian D. Boyd, M.D., Leslie A. Morgan, M.D., and Alvin Blum, B.S. South. M. J. 52:1-6 (Jan.) 1959.

The authors present a new method of determining renal function which offers interesting potential uses in the study of renal physiology and of renal disease. Their report is designed to show the types of curves or radiorenograms which have been obtained from patients with a variety of different renal abnormalities, as contrasted with those from patients with normally functioning kidneys, and to indicate briefly the manner in which the radiorenogram is to be interpreted. They describe the study of renal function through radioisotope technics by means of I^{131} tagged Diodrast and present typical radiorenograms in health and disease. It is their conclusion that the simplicity, speed, safety and definitive nature of results of the test recommend its employment as a screening agency and as a supplement to other tests for renal function now commonly employed.

Malignant Melanoma. By Frederick H. Bowen, M.D. and Robert A. Walton, B.A. Tr. South. S. A. 71:364-371, 1959.

Cancer has caused 26,922 deaths in Florida during the last five years. Malignant melanoma has accounted for 223, or 0.83 per cent of these. Of the 3,899 malignant lesions listed in the Tumor Registry at the Duval Medical Center, 0.83 per cent are melanomas. Negroes accounted for 56 per cent of these lesions and 31 per cent of the melanomas. White females were represented in 22 per cent of the total malignant lesions and 47 per cent of the melanomas. The mean age of onset was 60 years. The average size of the lesion when first diagnosed was 2.4 cm. The average lapse in time from onset of symptoms to seeking medical treatment was five months with no correlation between this period and the stage of the disease when first diagnosed.

As expected, the mean survival time (M.S.T.) was related to the stage of the disease at initial diagnosis: Localized involvement, 53 months M. S. T. with 30 per cent five year survivals; regional involvement, 15 months M.S.T. with 10 per cent five year survivals; and remote metastasis, 9.5 months M.S.T. with no five year survivals.

A pre-existing mole was reported at the site of the lesion in 53 per cent of the cases. Wide local excision with lymph node dissection for localized lesions gave a M.S.T. of 84 months, compared to 56 months for local excision alone. In continuity lymph node dissection when regional involvement was present offered 21 months M.S.T. in contrast to five months M.S.T. for local excision and lymph node dissection not in continuity.

Of interest were two cases treated by irradiation followed by surgery with a M.S.T. of 141 months. Since these cases seem to support, somewhat, Dickson's cases at Johns Hopkins, it is thought that use of irradiation in conjunction with surgery may deserve more investigation.

A review of the literature as to accuracy of diagnosis of melanoma was made, and the combined works of Becker, McMullan and Hubener, Swerdlow, and Bowen and Walton show that of 341 clinically diagnosed malignant melanomas, histologic agreement was made in only 39 per cent; and in 296 histologically proved cases, only 49 per cent were clinically suggested as malignant melanoma.

Simple Repair of Eyelid Margin Defects. By D. Ralph Millard, Jr., M.D. Am. J. Ophth. 46:386-389 (Sept.) 1958.

The author has devised a technique for removal of lid-margin tumors which is free of the objections associated with the traditional halving procedure. His method, consisting of vertical mucomuscular closure and horizontal skin closure, is here described. This method has been found effective in both upper and lower lids in margin excisions sacrificing as much as one third. If one half of the lid requires excision, then a canthoplasty will be necessary to allow the vertical mucomuscular closure. No ectropion, depression, or notching has been noted and, after a few weeks, it is difficult to find evidence of the operation. Although this technique is applicable to patients of all ages, it has its greatest usefulness in the aged, in whom malignant eyelid lesions are more common and in whom there are laxity, skin in abundance and wrinkles.

PRESIDENT'S PAGE

The New Frontier Versus the Old

While the present administration glosses and buffs the socialistic articles first introduced to the American scene by the New Deal promoters of government paternalism and handout, many of us can recall from experience or from schooling the monumental virtues of the old frontier, from 1620 to 1932, that contributed to this country's greatness. The New Frontier with a young head and a professorial body is already in labor, attempting to give birth to a litter of throwbacks. Such atavism can mislead us only further into the socialistic swamp in the center of a welfare state.

Have we become a nation of lemmings, rushing impulsively into a sea of subserviency to a superstate? Are the majority of our citizens completely convinced that the federal government can do a better job of providing such things as education of our children, medical care for all, slum clearance and the like? Can we, therefore, shortly anticipate a Federal Board of Education, a Federal Welfare Board, a Federal Urban Renewal Board?

What happened to the traits of rugged individualism and independent thinking that were responsible for the establishment in the old frontier of schools, colleges and hospitals, and for communities and churches taking care of their own unfortunate members? In those days, when a man's income was limited only by his capacity for work and ambition, back before a penalty was placed on effort and initiative, each American valued his self respect and his neighbor's esteem too highly to permit others to do for him what he was perfectly able to do for himself. This attitude applied to communities and states of the Union as well. In a government that is highly organized with bureaus upon bureaus, in a government that taxes so that it may spend and control, in a government that is a big brother to labor and restrictive to big business, it was inevitable that a decline in moral values would occur. The selfishness of the "I'm gonna get my share" attitude was only the beginning. It has fostered myriad forms of dishonesty from tax evasion to rigging of quiz shows and contract bidding, from juvenile delinquency to neglect of elderly parents, from robbing poor boxes to stealing ballot boxes. Honesty has become passé and sincerity is old hat. Real charity is questioned as to what is the gimmick, and the true patriot is suspected of ulterior motives.

The Fifth Amendment may have a proper place for protection under law. The Sixteenth Amendment has none. It has compounded our problems and made us a nation of alms seekers. Let the states collect even a portion of the taxes that go into the hands of the bureaucracy that is Washington, and they will do a better job, more efficiently patterned to their own needs in many of the fields being usurped by Uncle Sugar formerly considered reserved to the states as their rights, duties and functions. The values of the old frontier are gone but not forgotten.

I am fed up to here with the New Frontier.

Leo M. Wachtel

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Coffee at Bedtime for Angina Decubitus

The ubiquitous coffee drinkers have gradually extended the hours in which they partake of their cups of "Java" by adding midmorning, luncheon, and afternoon coffee breaks to the time-honored breakfast and after dinner cups. There are even many confirmed coffee drinkers who defy tradition and advertisements for de-caffeinated coffee by imbibing a steaming hot cup at bedtime to help them sleep. (These are the same persons who "need" the same drink to wake them up the next morning.)

A few of these bedtime coffee drinkers might well be advised against this custom: those whose rest is disturbed by frequent premature contractions and those who must respond to the diuretic effect of caffeine by frequent trips to the bathroom. Most of the nocturnal coffee drinkers suffer no ill effects and would not follow suggestions to omit coffee after dinner.

There is a small group of persons who often benefit from taking coffee at bedtime. These are the unfortunate sufferers from angina decubitus—the anginal pain that comes with the patient at rest. Although most patients suffering from angina decubitus will be found to have a myocardial infarction, anemia, or some other acute condition, there are those who have no evident explanation. During the day they will have typical angina pectoris on effort, but are comfortable at rest; yet when night comes, they awaken repeatedly with severe chest pain. Some will benefit from sleeping in a chair and others by prophylactic narcotics at bedtime. With an appreciable number the difficulty seems to be a progressive hypoxia secondary to slowing down of respirations during sleep, and these patients derive much relief from a small amount of coffee taken at intervals during the night.

The use of bedtime coffee for prevention of angina decubitus is not only physiological, but has the great advantage of avoiding more pills and "shots" for persons who are usually elderly, often chronically ill, and are already taking a variety of medicines. Most will realize that the morning coffee makes them feel better and will regard half a cup at bedtime as sensible advice. For those who fear insomnia, caffeine may be given in doses of 75 to 100 mg. in tablet or capsule form.

J. M. P.

Opinions expressed in editorials or commentaries, when signed or initialed, are those of the author and not necessarily of The Journal or the Florida Medical Association.

Medical School Applicants

Many articles have appeared in both the lay press and medical publications dealing with the knotty problems involved in producing doctors to care for the increasing population. Many of the problems involved are not the immediate concern of the practicing physician: establishment of new medical schools or expansion of existing schools, tapping new sources of financial aid, and shortening the time involved in the over-all educational experience required to produce a physician. These problems are best left to medical educators.

One problem in this field of medical education is most assuredly the immediate concern of the practicing physician: the encouragement of qualified high school and college students to enter medical school. Data available indicate a decline in both the quantity and quality of applicants for medical school. The reasons are numerous and well summarized by Perrin H. Long, whose editorial[1] is highly recommended reading.

Dr. Long emphasizes that medicine as a career faces stiff competition from the engineering and allied fields which offer more scholarship aid, shorter years of study, and higher starting incomes. But his greatest concern is that Medicine is fast losing its status as a "Learned Profession," a status shared until recently by Theology and Law. Membership in one of these "Learned Professions" was highly prized, and those who achieved it comprised the intellectual community of each country.

Dr. Long warns that by its orientation and practices Medicine is becoming regarded as a trade whose members are more concerned with the economics of medicine than the Art. He fears that the laity is losing faith in our aims, our code of etiquette, and our personal and professional ethics to the extent that the idealistic high school and college students are being repelled from becoming physicians. Let each of us do all in his power to restore our standing to that of a "Learned Profession" and the able youngsters will once again be attracted to a career in Medicine.

1. Long, P. H.: What Has Caused a Decline in Medical School Applicants? Medical Times 88:1221-1223 (Oct.) 1960.

J. M. P.

Eighty-Seventh Annual Meeting

Miami Beach, May 25-28, 1961

For its 1961 Annual Meeting the Florida Medical Association returns late next month to the greater Miami area for the sixteenth time. Miami Beach will be the host city, and the Americana Hotel in the Bal Harbour section will be the headquarters, as it was in 1958 and 1959. This famous resort hotel in the nation's most fabulous resort city offers unique facilities to expedite the meeting and attract a record attendance in an ideal setting. The dates this year are May 25 to 28, somewhat later than usual.

The approach as to schedule for this meeting is likewise unique, and the members of the Association will wish to take particular note of the changes and plan accordingly. Registration will begin on Thursday, May 25, at 11 a.m. The first session of the House of Delegates will convene at 1:30 on Thursday afternoon and the second session, beginning at 1:30 p.m. on Sunday, May 28, will conclude the meeting. Following the first session of the House of Delegates on Thursday, the annual Blue Shield meeting will take place at 3:30 p.m. Alumni and fraternity group meetings are planned for 6 p.m.

The General Session is scheduled for Friday at 11:30 a.m. At this time Dr. Leo M. Wachtel, President, will present his special guest, the Hon. George A. Smathers, United States Senator from Florida, who will address the Association.

Preceding the General Session on Friday, the First Scientific Assembly will open at 9 a.m. The Second Scientific Assembly will take place at 2 p.m., and the Third Scientific Assembly will be held at 9 a.m. on Saturday, May 27. The essayists and their subjects were announced in the March Journal. The Assembly on Friday morn-

ing will be devoted to diagnostic clinics on digestive diseases and cardiovascular diseases. In the afternoon six members of the Association will present papers, and at the Saturday Assembly five distinguished guest lecturers will be heard. At this concluding scientific session there will also be a panel on "What Do You See as the Future Treatment of Cancer?"

Saturday afternoon and evening and Sunday morning, May 27 and 28, will be reserved for meetings of the various specialty groups. Some will hold luncheon meetings and some dinner meetings on Saturday, and a number will hold sessions on both Saturday and Sunday.

The Board of Past Presidents will have its usual breakfast meeting on Friday at 8 a.m. At noon on Saturday the Florida Medical Committee for Better Government will meet in a luncheon session. At 4 p.m. on Sunday the Board of Governors will hold its postconvention meeting.

The chief social event will be the President's Reception. It will be held on Friday at 6:30 p.m. on the Starlite Patio.

Florida Association of Blood Banks
Fifteenth Annual Meeting
Miami, May 5-7

The Florida Association of Blood Banks will hold its fifteenth annual meeting at the DuPont Plaza Hotel in Miami on May 5, 6 and 7, 1961. The annual business meeting will be held on Friday evening, May 5, at 8:30, and on the following evening the annual banquet will take place at 7:30. The excellent program, planned by Mrs. Dorothy C. Smith, President-Elect and chairman of the Program Committee, is as follows:

FRIDAY, MAY 5, 1961

4:00 p.m. Meeting of Representatives of Small Blood Banks, John A. Shively, M.D., Bradenton, presiding

8:30 p.m. Annual Business Meeting

SATURDAY, MAY 6, 1961

Lloyd R. Newhouser, M.D., President, presiding

9:00- 9:15 Welcome Address
Willard L. Fitzgerald, M.D., President, Dade County Medical Association

9:15- 9:45 Pineapple, Papaya, Pancreas and Paradox
Clifford I. Argall, Ph.D., Memphis, Tenn.

9:45-10:15 Studies on the Immunology of Hemoglobin
John B. Miale, M.D., Miami

10:15-10:30 Discussion and view exhibits

10:30-11:00 The Protective Action of ABO Incompatibility on Rh Hemolytic Disease
Philip Levine, M.D., Raritan, N. J.

11:00-11:30 Medical-Legal Problems in Blood Banks
Franklin J. Evans, M.D., Miami

11:30-12:00 The Importance of Blood Bank Records
Melba Olson, Minneapolis, Minn.

12:00-12:15 Discussion and view exhibits
Adjourn for lunch

Mrs. Dorothy C. Smith, President-Elect, presiding

2:00- 2:30 Community Blood Bank Promotion
William Scheu, Jacksonville

2:30- 3:00 What AABB Means to You!
John R. Schenken, M.D., Omaha, Neb.

3:00- 3:30 Exchange Transfusion in the Erythroblastotic Newborn—Physiological Basis and Principles
Demetrius J. Traggis, M.D., Miami

3:30- 3:45 Discussion and view exhibits

3:45- 4:15 Donor Procurement for Massive Transfusions
Bernice Hemphill, San Francisco

4:15- 4:45 The Finger in the Dike
Clifford I. Argall, Ph.D., Memphis, Tenn.

4:45- 5:00 Discussion and view exhibits

7:30 Banquet

SUNDAY, MAY 7, 1961

9:00-10:00 Breakfast Meeting of New Board of Directors

10:00-12:30 Roundtable discussion on Blood Bank Administration

10:00-12:30 Technical Panel

"Transparent Twins" Exhibit Featured at Florida State Fair

"There'll be some head turning and eyebrow raising over some female forms exhibited at the Florida State Fair. But not shockingly, may we add hastily."

With these words, the Tampa Times began a feature article describing the American Medical Association's new "Transparent Twins" exhibit which was sponsored by the Florida Medical Association and shown in the 1961 Florida State Fair held at Tampa February 7-18. A conservative estimate puts the number of persons who saw the "Twins" at more than 21,000.

Physicians of the Hillsborough County Medical Association were present during the fair to answer questions and provide further explanations of the unique exhibit. Members of the Associaciation's Woman's Auxiliary provided assistance in staffing the exhibit and in directing the decoration of the attractive medical booth.

One of the life size transparent models shows the major internal organs and circulatory system. The other demonstrates the skeletal and nervous systems. Each organ and system is illuminated individually and its functions explained in a 15 minute self-contained tape recording.

Some 50 chairs in the exhibit booth were kept fllled with interested spectators during the 11 days of the fair. Thousands of pieces of literature, including the American Medical Association's new booklet, "The Cost of Medical Care," were distributed to the throngs visiting the exhibit.

Two years in preparation, the "Transparent Twins" are the newest in a series of improved exhibits from the national medical organization. The Association's outstanding exhibits in the State Fair have become an annually sought-after feature of the huge midwinter exposition.



Mrs. Maurice Haddad and Mrs. Lawrence A. Ratchford (in background), members of the Woman's Auxiliary to the Hillsborough County Medical Association, keep a watchful eye on crowds attending showing of American Medical Association's "Transparent Twins" exhibit at Florida State Fair in Tampa.

Cooperation Sought In Maternal Death Study

An analysis and a classification of all maternal deaths in Florida have been undertaken by the Committee on Maternal Welfare of the Florida Medical Association. Dr. James M. Ingram, of Tampa, Chairman, announced that the study began as of Jan. 1, 1961, but actual implementation was not initiated until March because of the routine delay of several months in the reporting and processing of official death certificates upon which the program depends for notification of deaths.

The maternal death study was authorized by the Association's House of Delegates in April 1960. Florida is the last among the Southeastern states to establish such a program.

The survey has two objectives: to determine as accurately as possible the factors responsible for each maternal death, and to make recommendations on a regional or statewide level aimed at eliminating preventable deaths.

The Committee on Maternal Welfare points out that it has no authority or desire to censure. No ethical, professional or legal liability is imposed upon any physicians by the Committee. In classifying deaths, the Committee frequently will utilize the state's two medical schools and various individual physicians for consultative services.

The Committee is notified of maternal deaths by the Bureau of Maternal and Child Health of the State Board of Health, which is cooperating in the program. A letter is then forwarded to the physician who signed the death certificate. Enclosed with the letter is a questionnaire requesting certain details concerning the patient's history, physical findings and management. If a consultant is listed, a similar letter is forwarded to him.

The survey is conducted on an impersonal basis. As complete information is obtained in each case, all names are removed from the record. After analysis, the records are filed permanently by number with all identification eliminated.

Prompt cooperation by all physicians is urgently requested in helping this program accomplish its worthwhile and necessary objectives. The Committee stresses that the ultimate purpose of the survey is the reduction of maternal deaths in Florida. To this end, the Committee solicits the help of all physicians and welcomes any questions or comments in regard to this important study. It is anticipated that the program will be conducted on a continuing basis.

Eleventh Annual Postgraduate Seminar Mount Sinai Hospital of Greater Miami Miami Beach, May 18-20

The Eleventh Annual Postgraduate Seminar of the Mount Sinai Hospital of Greater Miami will be held at the Seville Hotel in Miami Beach on May 18-20, 1961. The registration fee is $20 but interns and residents are registered without fee, upon presentation of identification.

A notable feature of the program is the Roundtable Discussion, an innovation this year, which will permit physicians in attendance to meet in smaller groups with the particular faculty member in whose subject they have a special interest. The faculty members and their papers are as follows: Gerson R. Biskind, M.D., Chief of Pathology, Mount Zion Hospital, San Francisco, Roundtable Discussion: "The Demonstration of Certain Experimental Endocrine Neoplastic and Nutritional Inter-Relationships and Their Clinical Implications," Formal Lecture: "Steroid and Gonadotropic Hormone Patterns in Certain Clinical Disorders," Panel: "Geriatrics;" Harvey Blank, M.D., Professor and Chairman, Department of Dermatology, University of Miami School of Medicine and Jackson Memorial Hospital, Miami, Formal Lecture: "Systemic Chemotherapy of Fungus Infections;" Henry L. Bockus, M.D., Professor Emeritus of Medicine, Graduate School Hospital, University of Pennsylvania, Philadelphia, Formal Lecture: "Prognosis in Peptic Ulcer Disease," Panel: "Geriatrics;" James H. Ferguson, M.D., Professor and Chairman, Department of Obstetrics and Gynecology, University of Miami School of Medicine and Jackson Memorial Hospital, Miami, Panel: Moderator, "Perinatal;" William Dameshek, M.D., Director, Blood Research Laboratory, New England Medical Center, Boston, Formal Lecture: "Systemic Lupus and Its Meaning." Roundtable Discussion: "Auto-Immune Disorders," Panel: "Perinatal," and Leon Ginzberg, M.D., Director of Surgery, Beth Israel Hospital, New York, Formal Lecture: "Present Concepts in the Management of Regional Enteritis," Roundtable Discussion: "Some Practical Features in the Management of Diseases of the Gastrointestinal and Biliary Tracts," Panel Discussion: "Geriatrics."

Other participants include: Jerome S. Harris, M.D., Professor and Chairman, Department of Pediatrics, Duke University, Durham, N. C., Formal Lecture: "Nephritis in Childhood," Roundtable Discussion: "Rheumatic Fever and

Congenital Heart Disease;" Arthur L. Haskins, M.D., Professor and Head, Department of Obstetrics and Gynecology, University of Maryland School of Medicine, Baltimore, Roundtable Discussion: "The Indications for and the Choice of Luteoid Substances in Obstetrics and Gynecology." Formal Lecture: "Bleeding Fibroids," Panel: "Perinatal;" Ralph Jones Jr., M.D., Professor and Chairman, Department of Medicine, University of Miami School of Medicine and Jackson Memorial Hospital, Miami, Formal Lecture: "Chemotherapy in Malignancy;" Mark M. Ravitch, M.D., Surgeon in Chief, Baltimore City Hospitals, Baltimore, Formal Lecture: "Abdominal Tumors in Infants and Children," Roundtable Discussion: "Problems in Colon Surgery, With Particular Emphasis on Hernia Repair, Ventral, Inguinal and Femoral, With Illustrations," Panel: "Surgical Emergencies in the Perinatal Period;" Winston K. Shorey, M.D., Associate Dean, University of Miami School of Medicine and Jackson Memorial Hospital, Miami, Panel Moderator: "Geriatrics," and Demetrio Sodi Pallares, M.D., National Institute of Cardiology, Mexico City, d.f., Mexico, Roundtable Discussion: "Electrophysiology and the Inscription of the Electrocardiogram," Formal Lecture: "The Polarizing Agents in Coronary Disease and Their Relation With the Electrophysiology of the Muscle Fibers," Panel: "Geriatrics."

Participants in the scientific program on Friday afternoon and their subjects are: Dr. Minas Joannides Jr., of St. Petersburg, "Current Management of Various Types of Emphysema;" Dr. Milton B. Cole, of St. Petersburg, "Studies in Emphysema. V. Long-Term Results Following Diaphragmatic Breathing Training on the Course of Obstructive Emphysema;" Dr. Mark W. Wolcott, of Coral Gables, "Spontaneous Pneumothorax;" Dr. Myron I. Segal, of Hollywood, "Spontaneous Pneumothorax and Its Management;" Dr. Fernando Valverde, of Miami, and Dr. Ivan C. Schmidt, of West Palm Beach, "Lung Cancer in a Tuberculosis Hospital;" Dr. Jack Reiss, of Coral Gables, "Carcinoma of the Lung and Cigarette Smoking;" Dr. Edwin Tutt Long, of Lakeland, "The Increased Vascular Resistance in Lungs Re-aerated After Chronic Atelectasis;" and Dr. Allan L. Armstrong, of Tampa, "Gas Chromatography in Clinical Chest Disease." On Saturday morning the speakers and their subjects are: Dr. Howard M. DuBose, of Lakeland, "Outpatient Treatment of Pulmonary Tuberculosis With Long Term Chemotherapy;" Dr. David M. Travis, of Gainesville, "Constrictive Pleuritis;" and Dr. Seabury, "Patterns of Diffuse Pulmonary Fibrosis."

Florida Thoracic Society Annual Meeting Program Jacksonville, April 28-29

The Florida Thoracic Society will hold its annual meeting on April 28-29, 1961, at the Hotel Robert Meyer in Jacksonville, in conjunction with the annual meeting of the Florida Tuberculosis and Health Association. Six hours of Category I credit will be given for attendance at the scientific sessions. The first scientific session will convene on Friday at 1:30 p.m. and the second and final scientific session on Saturday at 8:45 a.m. with the closing general session beginning at 11:00 a.m. Dr. George H. McCain, President, of Tallahassee, will preside at these sessions. The annual banquet will be held on Friday at 7:00 p.m. The guest speaker will be Dr. John H. Seabury, Professor of Medicine at Louisiana State University School of Medicine and his subject will be "Unusual Infections With Atypical Mycobacteria."

BLUE SHIELD

State Legislature

That time is here again. This month senators and representatives will converge on the state capitol in Tallahassee for the biennial 60 days of rush, confusion and procrastination, culminating in a flurry of last minute conversion of bills into laws, some of which will be surprisingly well conceived.

Judging by sessions which are now history, it may be anticipated that some 2,000 or more bills will be tossed into the hopper of the 1961 legislature. This means that they must be disposed of at the rate of 30 to 35 separate proposals each day. Yet, if this session is true to pattern, it will be deep into the waning days before any definitive action is taken on most of this proposed legislation, before any number of bills become ready for the Governor's consideration. This will be true except for so-called local bills, which will be ground through in record time and in unbelievable

quantities, when the legislative team from the area affected desires their passage.

It would be too much to expect that the entire session could pass without someone introducing measures designed to restrict the medical profession or its related organizations, or to promote socialistic proposals in the alleged interest of public health and welfare. Thus, it behooves each physician to know his senator and representatives well. Even more vital is to make certain that they know you and have confidence in your opinions on matters pertaining to medicine and health. Whether your legislators support or oppose sound health legislation is largely in your hands.

Blue Shield is largely in your hands, too. Your support of its aim to serve the entire community will influence these men to continue to support the principle that health care is a personal responsibility.

OTHERS ARE SAYING

Triple A

Today three A's seem to comprise the main criticism of the medical profession. We are accused of three great faults: (1) Anonymity, (2) Alienation, and (3) Antagonism.

Are you one of the great mass of doctors who is accused of hiding behind a facade of "organized medicine," who seek to be anonymous in a mass called American Medicine, who do not take a public or private stand on any social, moral or medical economics problems, and who excuse everything by the casuistic "they," that is the County, State or National medical organizations (as the scapegoats) for any dissatisfaction the public may have with medicine? Are you one of those who seeks to be anonymous in the public eye by not taking your part in the local, county or state organizations?

Are you suffering from Alienation? That is, are you one of those doctors who blames poor public or personal relations for the unenviable position of medicine today? We have poor public relations, no doubt, but what have you done personally or publically to change the "image" of the "modern doctor"? What are you doing personally to make the public appreciate doctors? Have you done anything to help your local society change the public unrest and dissatisfaction? Are you a doctor whose fees are never criticized, whose dedication is never questioned, and whose interest in public questions and social problems is welcomed and understood? Or are you suffering Alienation?

Finally, are you considered antagonistic? Do you try to help your fellow citizens and fellow practitioners understand the problems of medicine in a changing social order? Do you admit that the social order is changing? Have you any convictions as to how the social order should change? Do you take any stand, yes, even in political questions? Do you help formulate policies in your local medical society? Are you always criticizing attempts to make compromises with social change, insurance medicine, group medicine, labor union medicine, government medicine? Do you inactively, anxiously and anonymously further the alienation of the "doctor image" by a lack of positive information and positive action whether in private or in your local organization to the point where the average doctor is considered "agin" everything? That is antagonistic. We doctors must be "for something!"

DO YOU BELONG TO THE TRIPLE A?

The Stethoscope
Bulletin of Volusia County Medical Society
Volume 1—*No.* 5
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STATE BOARD OF HEALTH

Human Relations and Perinatal Mortality

Much has been said statistically and otherwise about decreasing prenatal care, the drop in the number of women who attend clinics or visit their private physicians. Recently Dr. Arthur J. Lesser,[1] Director of Health Services at the United States Children's Bureau, pointed out that this is no time for smugness. He reminds us that in some communities infant perinatal and maternal mortality is increasing. With Florida's relatively high death rates from these causes, it behooves us to consider Dr. Lesser's warning words. He states that "omission of prenatal care is rising about two per cent per year."

Dr. Norman Morris,[2] Professor of Obstetrics and Gynecology at the University of London, approaches this and broader problems in a thought-provoking discussion on "Human Rela-

tions in Obstetric Practice." Every reader will judge as to the applicability of these comments to American practices.

"For most women childbirth is their moment of greatest achievement and sometimes of greatest happiness. It is an immensely important emotional as well as physical event. . . . The influences that a woman meets during this time may have a tremendous psychological and social significance, and in my view, our present system often fails miserably. . . . The joys, hopes and wonder that the arrival of new life should bring are spoiled and splintered into loneliness, indignity and despair. The feeling of personal achievement is lost, drowned in a sea of inhumanity.

"Women attend antenatal clinics regularly, often as many as fourteen times. The clinic is usually drab and colorless, painted a bottle green, brown or dirty cream. There are rows of uncomfortable benches. There is an atmosphere of coldness, unfriendliness and severity more in keeping with the spirit of an income tax office. The clinic is often very overcrowded and, at best, a crude appointment system is in operation. Despite this, women often wait one to three hours. The interview itself is usually extremely brief and under such conditions there is little encouragement for the patient to ask questions or relieve herself of any nagging fears or doubts. Therefore she often remains in gross ignorance of what is happening to her. The doctors and nurses also remain virtual strangers since she rarely sees the same one at each visit.

"Doctors interviewing large numbers of women on an endless conveyor belt system inevitably lose their sensitivity. Not long ago I heard a senior obstetrician admit that even after seeing about eight patients he began to feel dizzy. Such an arrangement is terribly fatiguing and yet there is little evidence that much is being done to end this archaic system.

"Many hospitals encourage some form of classes for expectant parents but unfortunately there is often poor liaison between the people who run the classes and the staff of the labor ward. Virtually no studies have been done on the average patient's emotional response to pregnancy and labor. . . . As a result these preparation classes are very much in their infancy. But in their present form they do enable women to approach labor with confidence and to bring it under their own control. In my view, failure to provide such classes is as negligent in an emotional sense as it would be in a physical sense if there was failure to test the urine regularly during pregnancy.

"Why are some women . . . often shown very little kindness and sympathy? Why is there so little thought for the mother as an individual? How far is this situation the end result of poor training, and can it be prevented? Is this unsympathetic attitude a form of defense mechanism? . . . .

"Surely it is not necessary to know the answers to all these questions before we make some attempt to put our house in order. . . . We must destroy the illusion that the patient is a human being apart, someone quite unlike ourselves. We must get rid of that awful method of dividing patients into cooperative or uncooperative, into easy and difficult. This classification is largely based on how much regimentation the patient will stand without complaining. . . .

"Above all, we must prepare to leave our professional pedestal and communicate directly and naturally with the patients. Routines could be examined and unnecessary traditional procedures ruthlessly discarded to gain time to share with patients and learn about their problems. We as a profession may be wasting our time pursuing tasks which, having outlasted their original purpose, are now serving to deviate us, from our real purpose. . . ."

In an entirely independent statement Dr. Lesser of our own United States Children's Bureau reminds us that factors which make prenatal care acceptable and attractive are related to perinatal mortality. "It is the group of women who get little or no prenatal care that is contributing the major proportion of perinatal casualties, both maternal and infant. If we wish to make progress in reducing these casualties, the first step is an analysis of prenatal care in each of our maternity programs. The time has come for a concerted effort to stress the importance of early and continued good maternity care in order to reduce perinatal casualties just as was done twenty years ago to reduce the excessive maternal mortality."

The medical profession has the scientific knowledge and technical skill to alleviate urgent health problems. But a potential is not enough; the service must be sought and used. In some degree failure to attain our high goals will be related to failures in human relations.

1. Lesser, A. J.: National Needs and Resources in Newborn and Maternity Care, Bulletin of the American College of Nurse-Midwifery (Sept.) 1960, abstracted in "Briefs" published by Maternity Center Association (Dec.) 1960.
2. Morris, N.: Human Relations in Obstetric Practice, Lancet (Apr. 23) 1960, as abstracted in "Briefs," published by Maternity Center Association (Oct.) 1960.

STATE NEWS ITEMS

Dr. James N. Patterson of Tampa has been elected to a second 6 year term as a trustee-member of the American Board of Pathology.

Dr. J. Maxey Dell Jr. of Gainesville has been elected to a four year term on the Board of Chancellors, the governing body of the American Colleg of Radiology. The election of Dr. Dell took place during the 37th annual meeting of the College in Chicago February 8-11.

Dr. Ralph S. Sappenfield of Miami has been elected chairman of the executive committee of the World Federation of Society of Anesthesiologists.

Dr. DeWitt C. Daughtry of Miami has been elected president of the Southern Thoracic Surgical Association.

Dr. Charles K. Donegan of St. Petersburg will participate in the program of the 100th Annual Session of the Medical Association of the State of Alabama being held at Tuscaloosa April 27-29. On Friday, April 28, he will present a paper entitled "Future of Medical Care as It Pertains to Internal Medicine."

Dr. Samuel M. Day of Jacksonville, Secretary-Treasurer of the Florida Medical Association, was guest speaker at the meeting of the Baptist Memorial Hospital Auxiliary held the latter part of February. Dr. Day discussed "Socialized Medicine."

Dr. Walter W. Sackett Jr. of Miami attended recently a conference in Atlanta of the Surgeon General's Committee on Poliomyelitis Control. The principal purpose of the conference of physicians and scientists was to formulate definite recommendations to be employed in the continued prevention of poliomyelitis during the year of 1961.

Dr. Melvin M. Simmons of Sarasota has accepted appointment as a member of The National Foundation's Health Scholarship Committee for Florida.

Dr. G. Tayloe Gwathmey of Orlando presented a paper entitled "Contact Lens—Their Value and Problems" at the Second Annual Conference of the Florida Society for Prevention of Blindness held in Tampa March 11. Dr. Ambrose G. Updegraff of St. Petersburg served as program chairman for the Conference.

The Gill Memorial Eye, Ear and Throat Hospital at Roanoke, Va., will hold its Thirty-Fourth Annual Spring Congress in Ophthalmology and Otolaryngology and Allied Specialties, April 3 through April 8. There will be 20 guest speakers and 50 lectures.

Drs. Myron I. Segal of Hollywood; DeWitt C. Daughtry, E. Sterling Nichol and Jack Reiss of Miami, and Minas Joannides Jr. of St. Petersburg will participate in the program of the 27th Annual Meeting of the American College of Chest Physicians being held in New York City June 22-26.

The second section of the Crossroads Cancer Seminar will begin Monday, May 1, at Clearwater, and continue May 2 at Vero Beach, 8:30 p.m., Indian River County Memorial Hospital; May 3 at DeLeon, 6:00 p.m., Ponce DeLeon Springs and May 4 at Ocala, Silver Springs Restaurant. The Seminar is presented in cooperation with the Florida Division, American Cancer Society, the Florida State Board of Health and the local county medical society.

Dr. John D. Reeves Jr. of Gainesville, Professor of Radiology at the University of Florida College of Medicine, has been appointed chairman of the Refresher Course Committee of the Radiological Society of North America.

The Escambia Pediatric Society met with the Escambia Otorhinolaryngological Society for a dinner meeting in January. A general discussion concerning pediatric and otorhinolaryngological problems was developed. Talks on pertinent subjects were presented by Drs. Earl G. Wolf, Bernard M. Barrett, Jesse N. McLane and Chas. J. Heinberg. The meeting was conducted by the president of the pediatric group, Dr. Charles R. Benton.

A two day short course in Care of Premature Infants, offering 14 hours credit in Category I,

will be held at the Premature Demonstration Center, Jackson Memorial Hospital, Miami, June 8-9. For information write Bureau of Maternal and Child Health, Florida State Board of Health, P. O. Box 210, Jacksonville.

The Florida State Board of Health has announced acquisition of the new film "Radiation: Physician and Patient." Produced by the American College of Radiology in cooperation with the U. S. Public Health Service and Rockefeller Foundation, it is a 16 mm. film, color, running time 45 minutes. The film is available without charge from the Audio-Visual Library, Florida State Board of Health, P. O. Box 210, Jacksonville 1.

The Fifth Annual Seminar and Barbecue of the Watson Clinic held Saturday afternoon, March 4, in Lakeland was well received by approximately 150 physicians from eight central and north Florida counties. The program was cosponsored by the Florida Academy of General Practice and the Florida Medical Association. It was accepted for four hours' credit, category I, by the American Academy of General Practice.

The theme of the Seminar was "Recent Advances in Medicine," and a distinguished faculty presented the program: "Recent Advances in Stomach and Bowel Surgery," Samuel F. Marshall, M.D., Department of Surgery, Lahey Clinic, Boston; "Asthma," Harold E. Ratcliffe, Col., MC, USA, Chief, Allergy Section, Walter Reed General Hospital; "The Current Status of Auto-Immune Disease," A. McGehee Harvey, M.D., Professor of Medicine, Johns Hopkins School of Medicine, Baltimore; "The Development and Function of the Specialty Boards," Lawrence M. Randall, M.D., Secretary, American Board of Obstetrics and Gynecology, and "New Developments in the Field of Obstetrics and Gynecology," F. Bayard Carter, M.D., Professor and Director, Department of Obstetrics and Gynecology, Duke University School of Medicine.

The annual meeting of the American Society of Internal Medicine is scheduled for Saturday and Sunday, May 6-7, at the Eden Roc Hotel, Miami Beach. A cordial invitation has been extended to all Florida physicians whether or not their specialty is internal medicine.

The program includes, for Saturday morning: Dr. Lawrence E. Geeslin of Jacksonville, chairman of the annual meeting committee, presiding; Mr. James Brindle, Director of the Social Security Department, United Automobile Workers, "Labor's Concern with Medical Care;" Dr. Leonard W. Larson, President-Elect, American Medical Association, "Ten Out of Every Ten Doctors;" Walter J. McNerney, Professor of Hospital Management, University of Michigan, "The Social and Economic Responsibilities of the Physician;" and Dr. Chester S. Keefer, President, American College of Physicians, who at the Presidential Luncheon will discuss "Historical Evolution of Internal Medicine." For Saturday afternoon: Dr. Scheffel H. Wright, Miami, president-elect, Florida Society of Internal Medicine, presiding; Mr. Kenneth Williamson, Director, American Hospital Association, "Governments Rule and Health Affairs;" Boisfeuillet Jones, Special Assistant to the Secretary of Health, Education and Welfare, "The Administration's Proposals for Health Care —How Will They Affect the Internists?" Panel: "Can We Improve Medical Care; Can We Reduce the Cost?" Moderator, Dr. Charles K. Donegan, St. Petersburg, Panelists: Mr. Brindle, Prof. McNerney, Mr. Williamson, Mr. Jones, Dr. Larson and Dr. George Weaver, Stockton, Calif.

For Sunday morning: Dr. Sidney O. Krasnoff, Philadelphia, Pa., presiding; Dr. F. David Pomrinse, Chief, Health Professions Branch, Division of Public Health Methods, "The Internist and Group Practice;" Mr. Andrew E. Ruddock, Director, Bureau of Retirement and Insurance, United States Civil Service Commission, "Federal Employee's Health Benefit Acts of 1959;" Dr. Henry J. Lehnoff Jr., Member, Board of Trustees, American Society of Internal Medicine, "The Relationship of the American Society of Internal Medicine and Component Societies;" Prof. McNerney, "The Maintenance of Standards of Medical Practice;" Symposium: "Is the Quality of Medical Care Improved When the Patient Directly Participates in Its Payment?" Moderator: Dr. L. Philip Longley, Member, Board of Trustees, American Society of Internal Medicine. Participants: Dr. Pomrinse, Mr. Ruddock, Prof. McNerney, Mr. Brindle, Mr. Jones, Dr. Jere W. Annis, Lakeland, Dr. Bullock, Los Angeles.

Dr. Clyde O. Anderson of St. Petersburg, Vice President of the Florida Medical Association, was inadvertently omitted from the list of Association representatives at the 1961 Annual Conference of Presidents and Secretaries on page 1034 of the March, 1961, issue of The Journal.



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1. Krantz, J. C., Jr., and Carr, C. J.: The Pharmacologic Principles of Medical Practice, Baltimore, The Williams & Wilkins Company, 1958, p. 843.

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Each cc. contains:
Aristocort Triamcinolone Acetonide, 1 mg. . . . 0.1%
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7.5 cc. and 15 cc. push-button dispensers



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Tubes of 5 and 15 Gm.



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The anti-inflammatory and antipruritic efficacy of triamcinolone acetonide was shown by the prompt control of itching and resolution of affected areas. Cahn, M. M., and Levy, E. J.: A Comparison of Topical Corticosteroids: Triamcinolone Acetonide, Prednisolone, Fluoromethalone, and Hydrocortisone.

Antibiotic Med. & Clin. Ther. 6:734 [Dec.] 1959.

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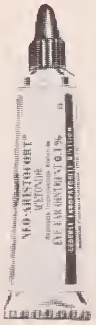
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Each gram contains:
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Precautions: Contraindicated in herpes simplex. Sensitivity reactions to neomycin occasionally occur.

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WOMAN'S AUXILIARY

"The Spouse in the Doctor's House"

Very little has been written on "How to be a Spouse in the Doctor's House;" however, it has been said that only strong, courageous, intelligent women, endowed with a sense of humor, marry doctors. These women can be assured of a life devoted to the service of others, which is a job for mature personalities. It is to the credit of the medical profession that their wives usually respect, admire and love their husbands, for the practice of medicine is a hard taskmaster; it develops the best in human character and favorably affects all who are encompassed by it. They are enobled by the pursuit of its aims and enriched by its unselfish ethics. That is why wives are enthusiastic disciples of the profession, even though doctors are exacting taskmasters and often are hard to live with.

Before a girl gets her Mrs. from an M.D., one of the prime prerequisites should be her pledge to the oath of Mrs. Hippocrates: "I do solemnly swear to abide by the precepts and examples set forth by the spouse of the famed healer Hippocrates.

"I do promise to wear a cheerful smile when my husband, the physician, fails to keep his appointments such as anniversaries, dinners, birthdays, celebrations and blessed events.

"I do also promise to keep smiling when he leaves the bridge party just as I am dealt the first five no trump hand in my life.

"I do pledge that I will harbor no jealousy in my heart, that I will appoint his receptionist, nurse, and technician on the basis of efficiency and not on age and appearance.

"Lastly will I be loyal, though he gives me aspirin for my brain tumor and soda water for my rheumatic heart."

There are some things that all doctors have in common. They are above average in intelligence. Being quick-witted, they are slightly intolerant to slow minded people. They are individualists who want their own way even a little more than do other men. They are very sensitive and are inclined to be egoists, since many of them have a deep sense of inferiority and insecurity. They are dedicated to their profession and the welfare of their patients, whose interest they



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Supplied: 200 mg. yellow scored tablets, and 100 mg. pink tablets, each in bottles of 100 and 500.

P.S. For the "Genericist", Dornwal is amphenidone

No absolute contraindications to the use of Dornwal are known. There have been no reports or evidence of habituation, addiction or drug tolerance in animal or clinical studies. Dornwal is relatively free from untoward effects when administered at recommended dosages.

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place above all others (even wife, home, children, money, social position and their own welfare). Therefore, they are not particularly good team mates except in medical undertakings. They are inclined to be lonely people except for their friendships with other doctors and their wives, but only other doctor's wives if they make an unusual effort to be friends with *them*. They are honest, conscientious; usually men of high integrity, who will not tolerate people who cut ethical corners. They have unusually high standards of accuracy, cleanliness, neatness and straight thinking. Their life has taught them to take it on the chin with a smile, and fundamentally they have little respect for anyone who does not do this. They make few excuses themselves and expect none from their associates. In general, they are virile, dynamic men with initiative. They are difficult, responsible, responsive, and dependable people who are easy to get along with only if they are handled properly.

Their lives are hard, their days are long, their responsibilities are almost greater than any one person should be asked to carry. Most of them earn a reasonably good living but their lack of interest in financial matters mitigates against wise management of their financial affairs. Throughout a long day they act a part, for the good of humanity; once off the professional stage and in their homes, they seek peace and quiet, free of the galling human eccentricities to which they have been subjected all day. It is not strange that in the quiet of their homes, when they let down, they may appear somewhat pessimistic, moody, and even irritable. Fatigue, both physical and emotional, is a doctor's greatest personal enemy. His wife's greatest opportunity is to prevent, and cure this fatigue—not by urging him to do less, not by making him sorry for himself, but by standing between him and the unthinking public, as well as by bringing him love and understanding, both in almost superhuman amounts.

But most of you are already familiar with the doctor's personal characteristics, although many of you entered this way of life without knowing the magnitude of your undertaking.

So, what are the characteristics which a woman should possess or develop if she is to do this job of being a "Spouse in a Doctor's House," successfully?

1. She must be intelligent, a person of sound integrity, possess good judgment, perception, deep understanding, sympathy, a quite sense of humor,

(Continued on page 1154)



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magnesium 3, 7-dimethyl-xanthine oleate

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Arteriosclerosis and its consequences:
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An effective aid for symptomatic treatment of arteriosclerosis. Athemol improves the circulation and well-being of the patient. Favorable response in patients with such symptoms as vertigo, mental confusion, chest pain, headaches, etc., often observed within a one or two-month period.

DOSAGE:
One or two tablets t.i.d. Available in tablets of 200 mg. each. Athemol is easily tolerated, and can be administered safely over a prolonged period.

REFERENCES:
(1) Buck, R. C.: Minerals of Normal and Arteriosclerotic Aortas, Arch. Path., 51, 1951. (2) N. Ressler, et al.: Relation of Serum Stability to the Development of Arteriosclerosis, Amer. J. Clin. Path. vol. 24, 1954. (3) S. D. Jacobson, M.D., Wayne County General Hospital, Eloise, Michigan. To be published. (4) Prof. V. Patzelt, Untersuchungen uber die Veranderunger der Bluteiweisz-Korper mit Mag. 3, 7-dimethyl-xanthine oleate, Klin. Med. 5, 11, 1956. (5) Dr. J. Skursky, Wiener Med. Wochenschrift, 1953, Nr 46, S. 886-887. (6) Eduard Keeser, M.D. and K. F. Benitz, M. D., Med. Klin. 1953 Nr. 15.

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MIDICEL (sulfamethoxypyridazine, Parke-Davis), 3-sulfanilamido-6-methoxypyridazine. Tablets of 0.5 Gm.; Suspension, each cc. containing 50 mg. of sulfamethoxypyridazine as the N'-acetyl derivative. *Indications:* Gram-negative and gram-positive infections such as urinary tract, respiratory, and soft-tissue infections and bacillary dysenteries. *Dosage:* Orally once a day until asymptomatic for 48 to 72 hours. Adults:—1 Gm. initially, followed by 0.5 Gm. daily thereafter or 1 Gm. every other day. In severe infections, not to exceed 2 Gm. the first day, then 0.5 to 1.5 Gm. daily according to weight of patient and severity of infection. Children:—30 mg. per Kg. the first day, then 15 mg. per Kg. daily. In severe infections, up to 50 mg. per Kg. initially, then 25 mg. per Kg. daily. Total dose in children, however, should not exceed lower dosage limits for adults. *Precautions:* Continue daily doses higher than 0.5 Gm. no longer than three to five days without checking for blood levels above therapeutic range. Maintain adequate fluid intake during therapy and for 48 to 72 hours afterward. Until further definitive information is available, MIDICEL, in common with all sulfonamides, is contraindicated in the premature and newborn infant. Contraindicated in patients with a history of sulfa sensitivity. MIDICEL is not recommended for meningococcal infections. *Side Effects:* Anorexia and lassitude may occur as may reactions such as drug fever, rash, and headache, all of which are indications for discontinuing the drug. Leukopenia has been reported. Periodic blood counts are advised. Patients with impaired renal function should be followed closely since excessive accumulation may occur. *Available:* Quarter-scored tablets of 0.5 Gm., bottles of 24, 100, and 1,000.

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(Continued from page 1150)

never failing tactfulness, and the ability to keep her mouth closed, even at home.

2. She needs to be a friendly, warm, outgoing person, who genuinely loves people, since she of necessity is in close contact with the doctor's patients and cohorts.

3. She must have social ease and grace—that is, she must be able to get along comfortably with groups of people *and* individuals.

4. She must be a well rounded person with intellectual interests. Doctor's wives need interests outside their homes, because otherwise they will be lonely or pathologically wrapped up in their children.

5. She must be that rare person—an able individual who can remain anonymous—the power behind the throne, who never lets even the kind suspect. This means that she needs to reach the ultimate in unselfishness, to give without thought of reward or recognition.

6. She needs considerable physical vigor, that she may tolerate early, late, and irregular hours. She is probably going to have to take care of the children without much help from her husband.

7. She must be an efficient, interest housekeeper, for the doctor does so many dirty jobs himself that he has little respect for clutter.

8. She should see to it that she looks her best and dresses attractively.

Being a doctor's wife carries a certain amount of occupational hazard, due to the realization that you are not first in his interests. Medicine is his great love. You must learn to deal with loneliness and repressed anger. First of all, try to understand him. It is not what you *think* he should be, but what he *actually is,* that you need to know. You can understand him better if you know his medical friends and their wives. Go with him to the medical conventions or any meeting he asks you to and encourage him to bring his medical friends home. Regular attendance at the Auxiliary meetings make you a better spouse because you get to know the other doctor's wives.

Help your husband balance his life in terms of work, rest, exercise and play. Do not keep him up late at night, and bring him home early from parties. Enter into the sports which he likes and try not to be better at them than he is. Do things with him even to the neglect of everything else. Encourage him to take vacations, both with and without you; but don't *you* go off on long summer vacations while he remains at home working. He needs the comfort of a well run home

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at all times. Enrich his life by bringing to him constructive, cultural interests for which there is little time in his busy life.

Help him to attain a reasonable amount of financial independence. Doctors are notoriously poor businessmen and their wives are little better. Be careful not to make too great financial demands on him. Help him to plan for the future.

Give him of yourself, wholeheartedly, without stint, spiritually and physically. Be warm, generous, uncritical and encouraging.

Encourage him to write medical papers, read medical journals and go to medical meetings. Stay up and wait for him when he comes home late from meetings and get up and give him a nice breakfast with a smile and your love.

As far as your good personal community relations are concerned, there are a few simple rules to keep in mind:

1. Always say less than you think. Cultivate a low, persuasive voice. How you say it often counts more than what you say.

2. Make promises sparingly and keep them faithfully, no matter what it costs you.

3. Praise good work done, regardless of who did it. If criticism is needed, criticize helpfully, never spitefully.

4. Be interested in others—interested in their pursuits, their welfare, their homes and families. Let everyone you meet, however humble, feel that you regard him as important.

5. Be cheerful. Hide your pains, worries and disappointments under a smile.

6. Keep an open mind on all debatable questions. Discuss but do not argue. It is a mark of superior minds to disagree but yet be friendly.

7. Discourage gossip. Make it a rule to say nothing of another unless it is something good.

8. Be careful of another's feelings. Wit and humor at the other fellow's expense are rarely worth the effort and may hurt where least expected.

9. Pay no attention to ill natured remarks about you. Simply live so that nobody will believe them.

10. Don't be too anxious about your "due." Do your work, be patient and keep your disposition sweet. Forget self and you will make few enemies.

In closing, may I share with you a reading from Proverbs 31:10-12? "A good wife who can find? She is far more precious than jewels. The heart of her husband trusts in her, and he will

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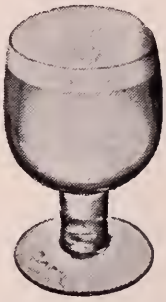
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A glass of beer can add zest to a patient's diet.

8-oz. glass supplies about ⅛ minimum Niacin requirements and smaller amounts of other B Complex Vitamins. (Average of American Beers)



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have no lack of gain. She does him good, and not harm, all the days of her life."

I offer the following prayer for all of us in the medical auxiliary:

Take us, O God, under Thy divine protection.
Make us to act as Thy messengers for contentment, harmony and understanding,
Grant that we may see more clearly the point of view of other men and women in our line of work, realizing the competitive nature of our business.
Teach us to respect competition at all times.
Keep us free from pettiness and unwise discrimination,
Let us do our work willingly, honestly and thoroughly, giving graciously at all times.
Teach us, to know and to realize that by Thy grace we can live in perfect peace with one another and grant that through this organization we may become closer in friendship and understanding, Amen.

Mrs. Russell B. Carson

Presented before the Woman's Auxiliary to the Palm Beach County Medical Society, January 25, 1961.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Sidney Storch of Jacksonville announce the birth of a son, Robert Phillip, on January 9, 1961.

Dr. and Mrs. William N. Chambers of Jacksonville announce the birth of a son, Cameron Hunter, on January 26, 1961.

Dr. and Mrs. Benjamin J. Phillips Jr. of Jacksonville announce the birth of a son, Michael David, on February 6, 1961.

Deaths — Members

Croft, George W., Jacksonville ..... March 3, 1961
Walters, Arthur L., Miami Beach ..... January 27, 1961

Deaths — Other Doctors

Lockwood, Edward K., Springfield, Ill. ..... May 13, 1960
McCurdy, Gordon J., Phoenix, Ariz. ..... February 14, 1960
Marshburn, Clarence B., Philadelphia, Miss. ..... February 6, 1961
Womack, David R., Austin, Texas ..... August 26, 1960

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DESCRIPTION

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Each dry filled vial contains: 1 Gm. STAPHCILLIN (sodium dimethoxyphenyl penicillin), equivalent to 900 mg. dimethoxyphenyl penicillin activity.

INDICATIONS

STAPHCILLIN is recommended as specific therapy only in infections due to strains of staphylococci resistant to other penicillins, e.g.:

Skin and soft tissue infections: cellulitis, wound infections, carbuncles, pyoderma, furunculosis, lymphangitis and lymphadenitis.

Respiratory infections: staphylococcal lobar or bronchopneumonia, and lung abscesses combined with indicated surgical treatment.

Other infections: staphylococcal septicemia, bacteremia, acute or subacute endocarditis, acute osteomyelitis and enterocolitis.

Infections due to penicillin-sensitive staphylococci, streptococci, pneumococci and gonococci should be treated with Syncillin® or parenteral penicillin G rather than STAPHCILLIN. Treponemal infections should be treated with parenteral penicillin G.

DOSAGE AND ADMINISTRATION

STAPHCILLIN is well tolerated when given by deep intragluteal or intravenous injection.

As is the case with other antibiotics, the duration of therapy should be determined by the clinical and bacteriological response of the patient. Therapy should be continued for at least 48 hours after the patient has become afebrile, asymptomatic and cultures are negative. The usual duration has been 5-7 days.

Intramuscular route: The usual adult dose is 1 Gm. every 4 or 6 hours. Infants' and children's dosage is 25 mg. per Kg. (approximately 12 mg. per pound) every 6 hours.

Intravenous route: 1 Gm. every 6 hours using 50 ml. of sterile saline solution at the rate of 10 ml. per minute.

* *Warning:* Solutions of STAPHCILLIN and kanamycin should not be mixed, as they rapidly inactivate each other. Data on the results of mixing STAPHCILLIN with other antibiotics are being accumulated.

DIRECTIONS FOR RECONSTITUTION

Add 1.5 ml. sterile distilled water or normal saline to a 1 Gm. vial and shake vigorously. Withdraw the clear, reconstituted solution (2.0 ml.) into a syringe and inject. The reconstituted solution contains 500 mg. of STAPHCILLIN per ml. Reconstituted solutions are stable for 24 hours under refrigeration.

For intravenous use, dilute the reconstituted dose in 50 ml. of sterile saline and inject at the rate of 10 ml. per minute.

*This statement supersedes that in the Official Package Circulars dated September and/or October, 1960.

(continued)

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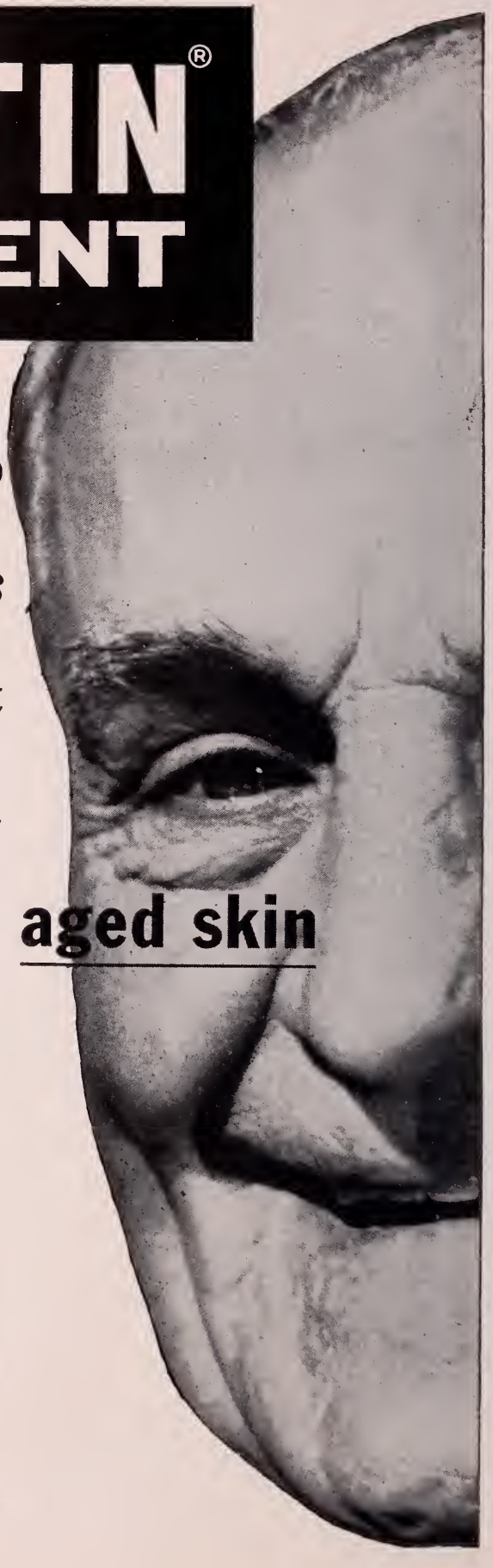
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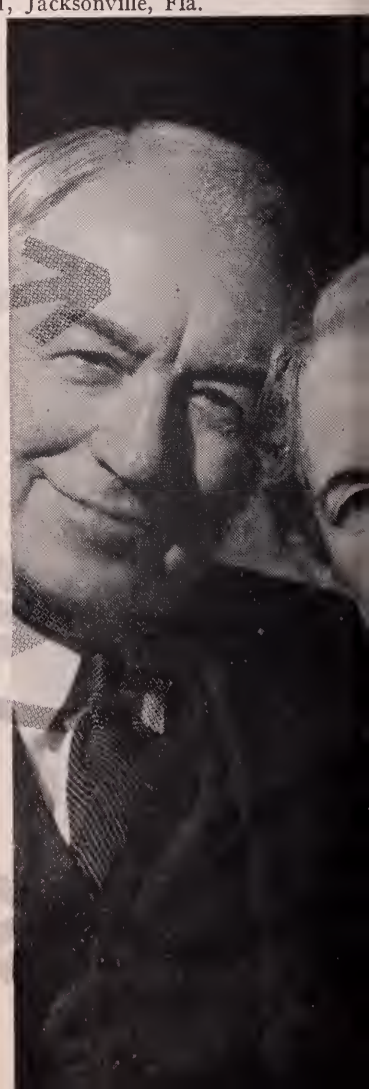
MEDICAL BUILDING: Newly completed, successful, 84 per cent occupied. Located on one of Fort Lauderdale's major traffic arteries. Has definite need for General Practitioner, Internist, Surgeon, Ophthalmologist. For information and literature, call or write RoMark Building, 3521 West Broward Boulevard. Reverse charges accepted. Phone LU 1-0900.

FOR SALE: Stainless steel cabinet on rollers with glass sliding doors. 84 x 36 x 12 inches. Sacrifice at fraction of cost, also Gomco Suction and stand. Albert S. Lasky, M.D., 1812 Hillview St., Sarasota, Fla.

WANTED: Industrial Medicine or Employee Health position in business or corporation. Full time. Have Florida license. Experienced and qualified. Young, female physician. Give full particulars. Write 69-412, P.O. Box 2411, Jacksonville, Fla.

arlidin

increases blood flow to the brain in the "senility syndrome" associated with cerebrovascular insufficiency



FOR SALE: General Practice in Southeast coast city. Fully equipped with X-Ray, EKG, Laboratory. Available immediately for cost of equipment. Write 69-411, P.O. Box 2411, Jacksonville, Fla.

INVESTIGATE Bradenton, Florida. Located in one of the fastest growing sections of the west coast. 40 miles south of Tampa. Need for General Practitioners, Pediatrician, Internist, Orthopedic Surgeon, Obstetrician and Dermatologist. Now leasing office suites in new 12,000 sq. ft. medical building. Occupancy about June 15. For specific information write or call George L. King Jr., Realtor, 524 - 10th St., Bradenton, Fla. Phone 6-1121.

RADIOLOGIST: Available in August. 17 years experience private and hospital work. Diagnosis, therapy, radium, isotopes. Associate or hospital. Write 69-413, P.O. Box 2411, Jacksonville, Fla.

GENERAL SURGEON: Board eligible. Age 40. Desires association or group. Three years General Practice experience. Married, family. Complete training July 1961. Write 69-414, P.O. Box 2411, Jacksonville, Fla.

WANTED: Internist, 8 years academic teaching, 3 years General Practice, passed American Board Internal medicine (written), desires group practice in clinic or partnership with Internist in Florida. Florida license, married, age 44. Write 69-401, P.O. Box 2411, Jacksonville, Fla.

WANTED: Obstetrician to join Southern Florida medical group. Florida license and a minimum of two years of residency required. Practice is waiting. Qualifications and inquiries to 69-415, P.O. Box 2411, Jacksonville, Fla.

RADIOLOGIST: American Board. Florida license. Wishes to contact small hospital or clinic near Dunnellon, Florida. Available for interview. Write 69-416, P.O. Box 2411, Jacksonville, Fla.

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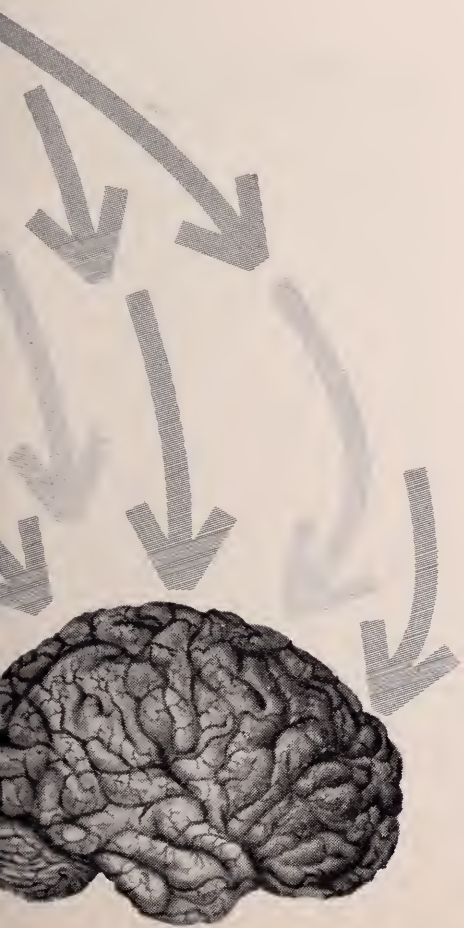
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Inadequate cerebral blood flow—often due to cerebral arteriosclerosis—may result in the "senility syndrome" with its pattern of mental confusion, memory lapses, depression, fatigue, apathy and behavior problems.[1-3]

43% increase in cerebral blood flow with Arlidin[4]

In patients with cerebrovascular insufficiency, Eisenberg[4] measured a 43 percent increase in blood flow in the brain following administration of Arlidin orally for more than two weeks beginning with a dosage of 12 mg. t.i.d. and increasing to 18 mg. t.i.d. There was a decrease in cerebral vascular resistance in most instances.

Winsor and associates[3] found Arlidin "of particular value **clinically** in relieving some of the symptoms of cerebral vascular insufficiency (vertigo, lightheadedness, mental confusion, diplopia)."

Arlidin is a unique and dynamic vasodilator which acts to increase circulation in the brain...in the inner ear and eye...also in the peripheral skeletal muscle.

arlidin®

(BRAND OF NYLIDRIN HCl NND)

references: 1. Madow, L.: Penn. M. J. 62:861, June 1959. 2. Stieglitz, E. J.: Geriatric Medicine, ed. 2, Philadelphia, Saunders, 1949 p. 274. 3. Winsor, T., et al.: Amer. J. Med. Sciences 239:594, May 1960. 4. Eisenberg, S.: ibid, July 1960.

NOTE—before prescribing ARLIDIN the physician should be thoroughly familiar with general directions for its use, indications, dosage, possible side effects and contraindications, etc. Write for complete detailed literature.

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relieve

COLIC

when due to cow's milk allergy

In a clinical study[1] of 206 milk-allergic infants, the "colicky" symptoms evident in 31% were promptly relieved when the infants were placed on a soya formula.

1. Clein, N. W.: Pediat. Clin. North America, Nov., 1954, pp. 949-962.

FOR PREVENTION: When allergic tendencies exist in parents or siblings, it is advisable to start the "potentially allergic" newborn on Sobee.

FOR DIAGNOSIS: If cow's milk allergy is suspected, a 24- to 48-hour trial period with Sobee often eliminates the need for an allergy study.

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SOBEE®



Hypoallergenic soya formula

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Symbol of service in medicine

OBITUARIES

Frank Vann Chappell

Dr. Frank Vann Chappell of Tampa died suddenly on Nov. 20, 1960, in Bradenton. He was 60 years of age.

A native Floridian, Dr. Chappell was born on Dec. 30, 1899, in Jacksonville, the son of Mr. and Mrs. Angus Rush Chappell. After finishing high school in Sanford in 1919, he attended Southern College in Lakeland, where he was awarded the A.B. degree in 1923. He then worked as auditor with a large business firm in West and North Florida until he entered the University of Tennessee College of Medicine in 1926. He received his medical degree from that institution in 1930. After completing a rotating internship at the Duval County Hospital in Jacksonville in 1931, he served a medical residency at the Good Samaritan Hospital in Phoenix, Ariz. in 1932.

Returning to Florida, Dr. Chappell practiced medicine in Hastings and Madison from 1932 until April 1935, when he entered the Johns Hopkins University School of Medicine for a short course in Public Health and Preventive Medicine. He then served as district and local health officer in Florida until he returned to the Johns Hopkins University in September 1936 for further study, receiving the degree of Master of Public Health there in April 1937. Thereafter, he served the Florida State Board of Health as Director of the Maternal and Child Health Program, Director of the Mobile Health Unit, and Director of the Bureau of Local Health Services. In 1942 he entered the Army Medical Corps as a captain and spent most of his military service in the South Pacific until he was returned to the States because of physical disability and was discharged as a major. Since 1945 he had been Director of the Hillsborough County Health Department. He maintained a strong local health department along traditional lines and also introduced many progressive measures into Florida Public Health activities, such as supervision of day nurseries and kindergartens, county-wide rabies control, and county-wide supervision of milk production and distribution. He was a member of the Tampa Kiwanis Club.

Dr. Chappel was a member of the Hillsborough County Medical Association and had held

(Continued on page 1178)



The FIRST Hematinic to Contain BOTH CHELATED IRON and CHELATED MINERALS Assuring a Truly Flavorful, Better Tolerated Iron Therapy.

ADVANTAGES —
Chelated Iron PLUS 4 Chelated Minerals • High Therapeutic Effectiveness • Less Irritation — even on empty stomach • No Tooth Stain • Less Toxic • B-Vitamins for Added Hemopoietic Activity • Pleasant Flavor • Economical

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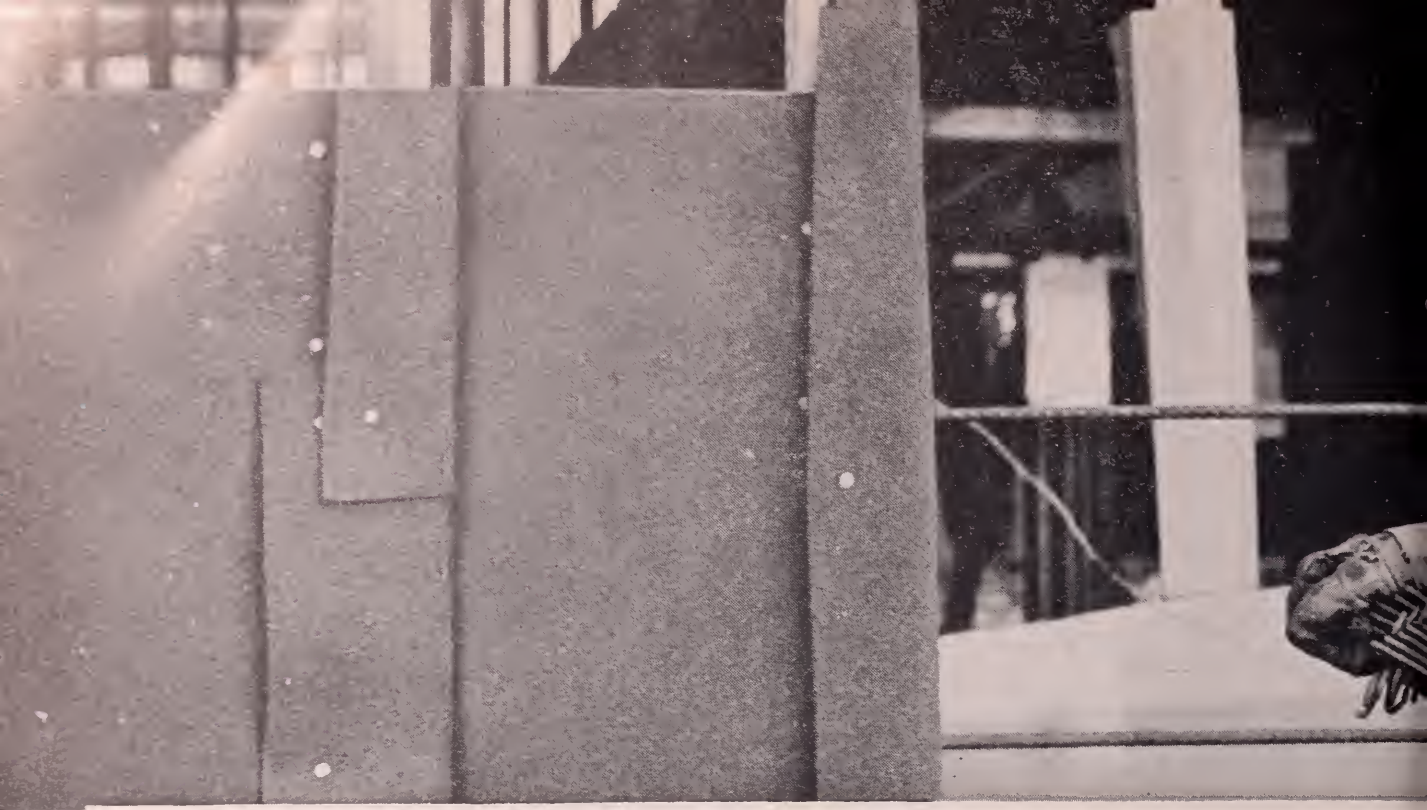
FORMULA —
Each 5 cc. (one teaspoonful) contains:

Iron (as Ferraus Betaine Citrate)	30 mg.
Cobalt (as Cobaltaus Betaine Citrate)	0.1 mg.
Manganese (as Manganese Betaine Citrate)	1.0 mg.
Zinc (as Zinc Betaine Citrate)	1.25 mg.
Magnesium (as Magnesium Betaine Citrate)	6.0 mg.
Vitamin B-1	1.5 mg.
Vitamin B-2	1.2 mg.
Vitamin B-12	6.0 mcg.
Niacinamide	10 mg.
Panthenal	10 mg.

In an exceptionally pleasant tasting base.

Comprehensive literature and samples on request.

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Put your low-back patient back on the payroll

Soma's prompt relief of pain and stiffness can get your low-back patients back to work in days instead of weeks

Soma is unique because it combines the properties of an effective muscle relaxant and an independent analgesic in *a single drug*. Unlike most other muscle relaxants, which can only relax muscle tension, Soma attacks both phases of the pain-spasm cycle at the same time.

Thus with Soma, you can break up both pain and spasm fast, effectively . . . help give your patient the two things he wants most: relief from pain and rapid return to full activity.

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only with higher dosages. Soma is available in 350 mg. tablets. Usual dosage is 1 tablet q.i.d.

The muscle relaxant with an independent pain-relieving action

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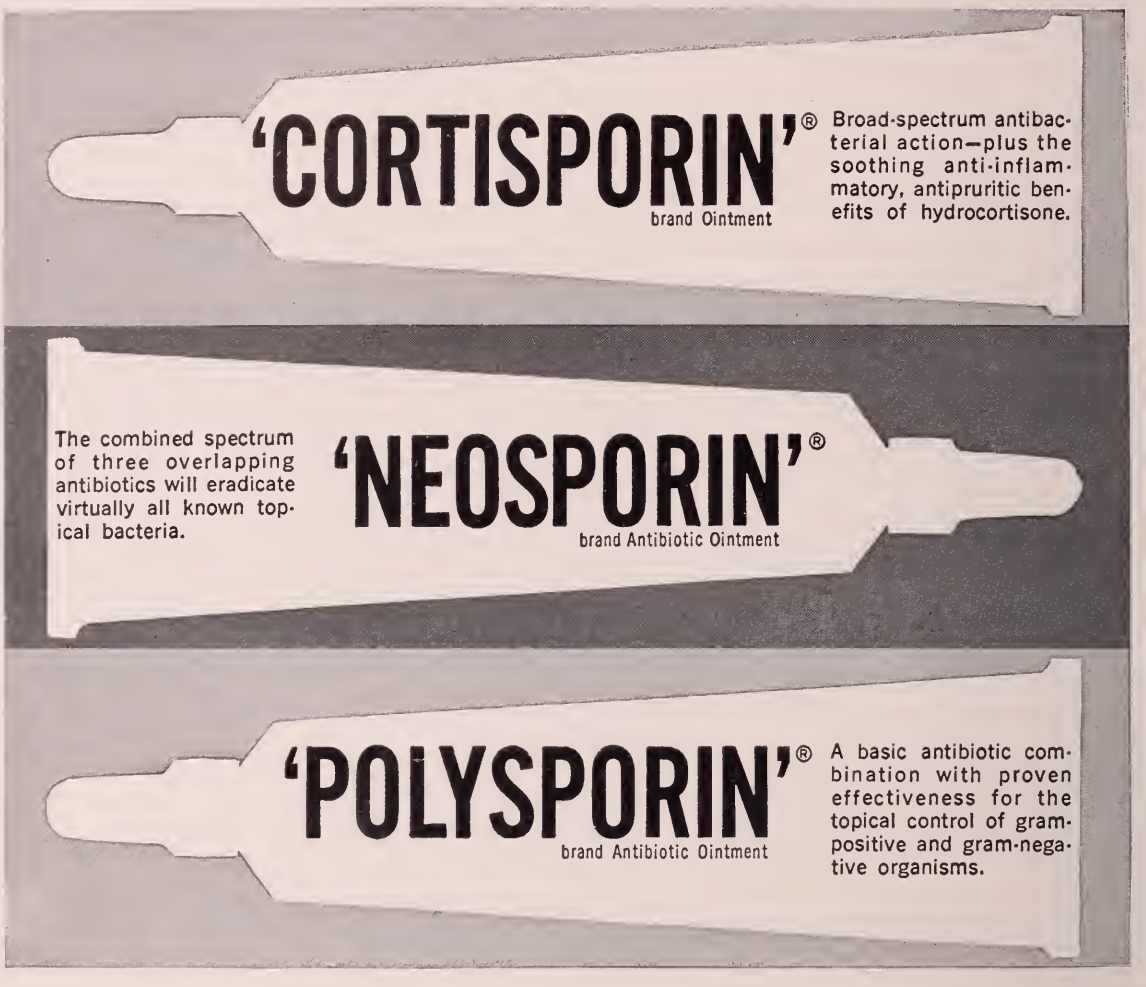
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Kestler reports in J.A.M.A. (April 30, 1960) that conventionally treated low-back syndrome patients required an average of 41 days for full recovery (range: 3 to 90 days). The addition of Soma therapy in this comparative investigation reduced the average to 11.5 days (range: 2 to 21 days). With Soma, patients averaged full recovery 30 days sooner.

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'Aerosporin'® brand Polymyxin B Sulfate	10,000 Units	5,000 Units	5,000 Units
Zinc Bacitracin	500 Units	400 Units	400 Units
Neomycin Sulfate	—	5 mg.	5 mg.
Hydrocortisone	—	—	10 mg.
Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)

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SUCCESSFUL FAMILY PLANNING...BASED ON YOUR COUNSEL AND LANESTA® GEL

Every young couple about to be married needs advice of all sorts, and they'll get it, too — from everybody — some good, some bad. But some of the most valuable counsel they can get — help in planning their own family — comes best from you. Their family happiness for many years can depend on what you suggest to them, including your recommendation for the use of Lanesta Gel.

Lanesta Gel, with or without a diaphragm, is a most effective means of conception control. Lanesta Gel offers faster spermicidal action because it rapidly diffuses into the seminal clot. In fact, Gamble ("Spermicidal Times of Commercial Contraceptive Materials — 1959"*) *found the mean diffusion spermicidal time of Lanesta Gel to be three to seven times faster than the mean diffusion times of ten leading commercially available contraceptive creams, gels, or jellies.*

Lanesta Gel has complete esthetic acceptance and is well tolerated. *Gamble, C. P.: Am. Pract. & Digest. Treat. *11*:852 (Oct.) 1960.

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Now—From the makers of Fleischmann's Margarine comes the...

First Unsalted Margarine Made from 100% Golden Corn Oil!

- ✳ Wonderful for sodium-restricted diets—10 mgs. of sodium per 100 grams!
- ✳ Contains polyunsaturated liquid corn oil and partially hydrogenated corn oil!
- ✳ Delicious flavor like the sweet, high-priced spread!
- ✳ Fresh-Frozen—available only in grocers' frozen food cases!



Fleischmann's Margarine was the first to make available the benefits of 100% corn oil with the lightly salted flavor preferred by so many.

Now, Fleischmann's has also perfected a new unsalted margarine for patients on low-sodium diets, and for those who simply prefer the sweet taste of an unsalted spread. It's new Fleischmann's Sweet (Unsalted) Margarine, also made from 100% corn oil, with a linoleic acid content three times higher than regular margarines and ten times higher than the high-priced spread.

Smooth, Fresh Flavor Preserved By Exclusive Fresh-Frozen Process!

This new unsalted margarine has a light, fresh flavor your patients will find delicious. And because it contains no salt or other preservatives, it's Fresh-Frozen for flavor protection. You can be sure it's always fresh and pure.

Although this new margarine is Fresh-Frozen, the quarter in use may be kept in the refrigerator as any other spread. The remaining quarters should be stored in the freezer.

Recommend The One That's Best For Your Patient

If your patient needs sodium restriction or prefers the flavor of an unsalted table spread, recommend new Fleischmann's Sweet (Unsalted) Margarine. It comes in a *bright green* foil package in the grocer's frozen food case. Or, if you want your patient to use a corn oil margarine, and salt is no problem, then recommend lightly salted Fleischmann's Margarine. It's in the *golden* foil package in the refrigerated case.



By the Makers of Fleischmann's Yeast

Fleischmann's CORN OIL MARGARINES...
Both made from 100% CORN OIL



Coca-Cola, too, has its place in a well balanced diet. As a pure, wholesome drink, it provides a bit of quick energy ... brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK
Coca-Cola
TRADE-MARK ®

Today... a growing bibliography confirms the importance in modern medical practice of

wine

"In...recent years,...comprehensive programs of wine research have been instituted in many university laboratories and clinics....Among the most recent findings are new evidence of *dry* wines' value in the treatment of diabetes...; the detection of wine components which act as mild cardiac stimulants; marked effects in reducing basic emotional tension...in protecting against the shocks of sudden stimuli (both of these at very moderate blood-alcohol levels), and somewhat startling values in treating diseases of the digestive tract.

"Especially good news to doctors are findings that certain wines are the most effective natural liquid stimulants of appetite for their convalescent patients; that the low sodium content of the beverage permits its inclusion in the unpleasant low-salt diets of patients with heart trouble; and, finally, measured proof of wine's value in promoting euphoria."*

For a scientific discussion of the modern ℞ uses for wine in convalescence, cardiology, urology, geriatrics, write for "Uses of Wine in Medical Practice," Wine Advisory Board, 717 Market Street, San Francisco 3, California.

*Adams, L. D.: The Commonsense Book of Wine, New York, David McKay Company, Inc., 1958, pp. 162-163.



For the build-up in convalescence

ANNOUNCING

FILMTAB® SURBEX-T™

Therapeutic dosage of B-Complex plus 500 mg. of Vitamin C

Unsurpassed stability. As coatings are applied without water, deterioration due to moisture is virtually eliminated. Stability is enhanced; potency is protected. **Easier, more pleasant to take.** SURBEX-T tablets are up to 30% smaller; have a pleasant taste; and are non-caloric. Vitamin odor and aftertaste are eliminated.

Each Filmtab SURBEX-T represents:

Thiamine Mononitrate (B_1)	15 mg.
Riboflavin (B_2)	10 mg.
Nicotinamide	100 mg.
Pyridoxine Hydrochloride	5 mg.
Cobalamin (Vitamin B_{12})	4 mcg.
Calcium Pantothenate (as calcium pantothenate racemic)	20 mg.
Ascorbic Acid (as sodium ascorbate)	500 mg.
Desiccated Liver, N. F.	75 mg.
Liver Fraction 2, N. F.	75 mg.

Supplied in bottles of 100 and 1000

VITAMINS BY ABBOTT

Filmtab coatings protect this full range of Abbott nutritional supplements:

SUR-BEX® WITH C. Smaller dosages of the essential B-Complex and C. Table bottles of 60. Also in bottles of 100, 500 and 1000.

DAYTEENS™ To help insure optimal nutrition in growing teenagers. Table bottles of 100, bottles of 250, 1000.

Potent maintenance formulas —ideal for those who are "nutritionally run-down"

DAYALETS® Table bottles of 100. Bottles of 50, 250, 1000.

DAYALETS-M® Apothecary bottles of 100 and 250. Also in bottles of 1000.

Therapeutic formulas for more severe deficiencies—illness, infection, etc.

OPTILETS® & OPTILETS-M® Table bottles of 30 and 100. Bottles of 1000.

®FILMTAB—FILM-SEALED TABLETS, ABBOTT.
TM—TRADEMARK
1961, ABBOTT LABORATORIES 103029A

Filmtab® Coating Advantages in a Nutshell





Tablets are easier to swallow, up to 30% smaller.



Vitamin after-taste and odor are eliminated.



Tablets are pleasant tasting, non-caloric, come in a rainbow of cheerful colors.



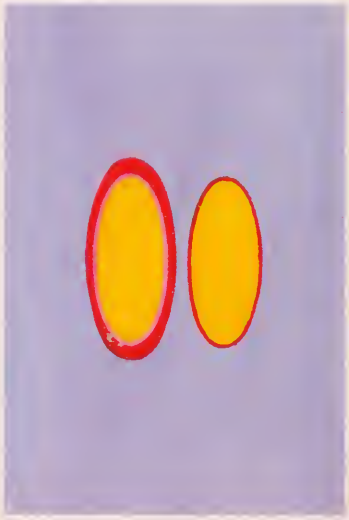
Breakage and cracking are less likely. (Sugar coatings are crystalline, and more brittle.)



In contrast with sugar coatings, no water is used in manufacture.



This eliminates the need of protective subseals, and chances of moisture seepage through imperfections.



Absorption is speeded as sugar's bulk and subseals are eliminated.

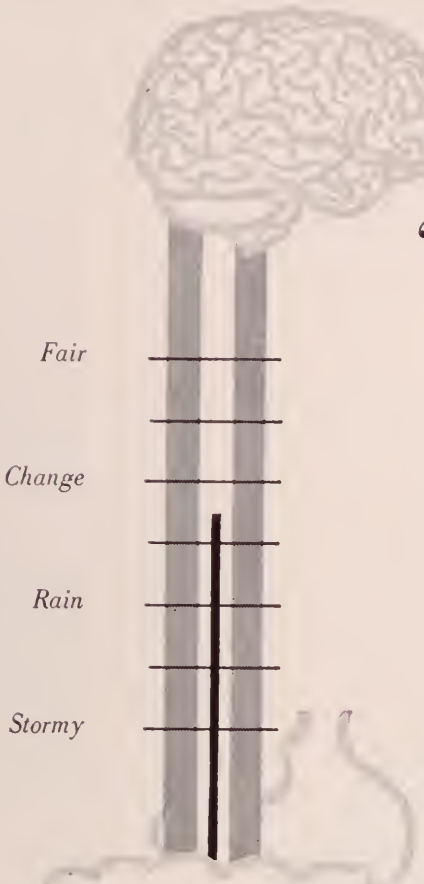


Vitamins are readily available at proximal receptor sites.

NET RESULT: Potency is assured for a longer time. The patient gets what he pays for—and what you prescribe.

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of the mind..."

Belbarb
soothes the agitated mind
and calms the G-I spasm
through the central effect
of phenobarbital and the
synergistic action of
fixed proportions
of natural belladonna
alkaloids on the
gastrointestinal tract.

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20 years of clinical satisfaction

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as easy and pleasant to use as a fine cosmetic

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Joseph Sunnen, an inventor and in trialist widely known for his philanthr work, became concerned about the ous economic problems caused by high birth rate in Puerto Rico. There an obvious need in that country f contraceptive more acceptable to people than the standard creams jellies.

He suggested combining a proven s micidal agent with an aerosol foan a basic carrier. The resulting proc Emko Vaginal Foam, proved simpl use, free of greasiness, and econom

For the past three years, Emko has b made available in Puerto Rico thro the Family Planning Association and Government Department of Health. proximately 35,000 families are using it.

The success of Emko Vaginal Foar Puerto Rico, and the support it has ceived from the many people who l visited there, led to the decision to n Emko available to doctors and their tients in the United States.

NOW YOU
PUT YOUR PATIENT'S M
AT EASE...WITH EM

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VAGINAL FOAM*

sing principles never before applied to contraceptives

• THE FIRST AEROSOL FOAM!

The volume of the material is expanded ten times to create A BLOCK OF FOAM.

• THIS BLOCK SEALS THE CERVICAL OS.

Only a FOAM can successfully serve this diaphragm-like function . . . without interfering with normal intercourse or reducing sensory contact.

• A HIGHLY EFFECTIVE PROVEN SPERMICIDE

EMKO Vaginal Foam contains the widely used and thoroughly proven spermicide Nonyl phenoxy polyoxyethylene enthanol 8.0% and Benzethonium Chloride 0.2%.

The total surface area of each bubble of foam contains this highly effective spermicidal combination. As the sperm attempts to penetrate the block of foam, its zig-zag course exposes it constantly to this very large contact area created by the bubbles.

Thus, Emko Vaginal Foam assures maximum spermicidal exposure . . . with a minimum weight of material.

- **No douching . . . it vanishes after use**
- **Absolutely no greasiness or "after-mess"**
- **No diaphragm . . . the foam does the blocking**
- **No irritation for husband or wife**



MARGARET SANGER RESEARCH BUREAU/**INTERIM REPORT**

In the Contraception Service of the Margaret Sanger Research Bureau, through October 31, 1960, Emko had been used from one to 22 months by 362 patients, with a total of 12 unplanned pregnancies. Seven of the pregnant patients admitted irregularity in the use of Emko.

Two planned pregnancies had also occurred after stopping the use of Emko.

A. J. SOBRERO, M.D. *Research Director*

*PAT. NO. 2,943,979. OTHER PATS. PEND.

(Continued from page 1167)

membership in the Florida Medical Association for 27 years. He was also a member of the American Medical Association, the American Academy of Preventive Medicine, the Florida Public Health Association, of which he was a past president, the American Public Health Association, and the Florida Association of County Health Officers, of which he was also a past president. In addition, he was a charter member of the American Association of Public Health Physicians.

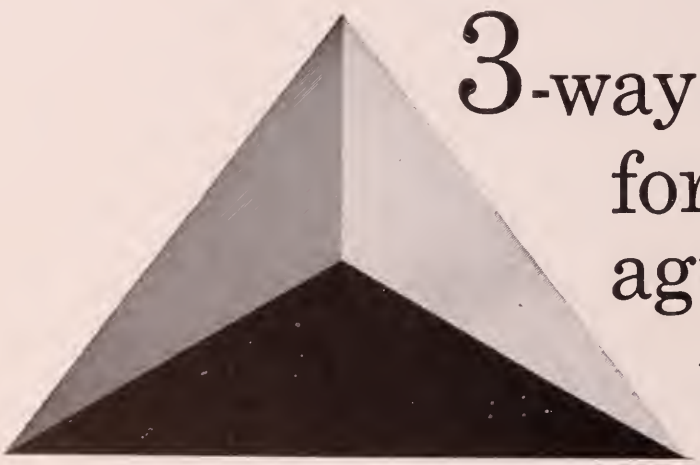
Surviving are the widow, Mrs. Frances Richards Chappell, of Tampa; two daughters, Miss Lindsey Chappell, a student at Jacksonville University, and Mrs. Hugh Barnett, of Tampa; two step-children, Miss Gwen Anderson and John Anderson, both of Tampa; his mother, Mrs. A. R. Chappell, of Jacksonville; a sister, Mrs. Harris G. Sims, of Lakeland; two brothers, Henry Chappell and Thomas Chappell, both of Jacksonville, and one grandchild.

Ralph J. Greene

Dr. Ralph J. Greene of Perry died on Aug. 3, 1960 at his Dekle Beach residence near that city. He was 72 years of age. Death was attributed to a heart attack.

Born at Georgetown, Ga., in 1887, Dr. Greene was educated in his native state. He received his medical training at Emory University School of Medicine in Atlanta and was awarded the degree of Doctor of Medicine by that institution in 1914. He came to Florida that same year, first to visit the late Dr. Collins in Perry and later to enter the general practice of medicine there. After serving as a captain in the Army Medical Corps in World War I, he returned to re-establish his practice in Perry. Locally, he was a member of the medical staff of Doctor's Memorial Hospital. Prominent in civic affairs for many years, he held membership in the Elks Lodge, the Masonic Lodge, the York Rite Body of Monticello, the Shrine of Morocco Temple, the Perry Shrine Club, the American Legion and the Rotary Club. He was a member of the First Baptist Church of Perry and a director of the local Florida National Bank.

Dr. Greene was a member of the Taylor County Medical Society and served as its secretary from 1955 to 1957. He was a life member of the Florida Medical Association, having held mem-



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ASSISTS PROTEIN UPTAKE
IMPROVES MENTAL OUTLOOK
AIDS NUTRITIONAL INTAKE

NEW

1 small capsule every morning

GEVRESTIN®

Geriatric Vitamins-Minerals-Hormones-d-Amphetamine Lederle

Each capsule contains: Ethinyl Estradiol 0.01 mg. • Methyl Testosterone 2.5 mg. • d-Amphetamine Sulfate 2.5 mg. • Vitamin A (Acetate) 5,000 U.S.P. Units • Vitamin D 500 U.S.P. Units • Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate 1/15 U.S.P. Unit (Oral) • Thiamine Mononitrate (B_1) 5 mg. • Riboflavin (B_2) 5 mg. • Niacinamide 15 mg. • Pyridoxine HCl (B_6) 0.5 mg. • Calcium Pantothenate 5 mg. • Choline Bitartrate 25 mg. • Inositol 25 mg. • Ascorbic Acid (C) as Calcium Ascorbate 50 mg. • l-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as $CaHPO_4$) 35 mg. • Phosphorus (as $CaHPO_4$) 27 mg. • Fluorine (as CaF_2) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K_2SO_4) 5 mg. • Manganese (as MnO_2) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as $Na_2B_4O_7.10H_2O$) 0.1 mg. Bottles of 100, 1000.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



Why Homer Jackson's work is important to you...

king on the radio-telephone is ner "Bud" Jackson, both a scientist a hard-working buyer for a company essing Florida oranges into frozen concentrate.

le has just made a decision that's ortant to you. He has analyzed some ple oranges from the grove in the ground and found that they have optimal amount of sugar, of acid, and are of the proper texture. (Testing for vitamin C comes later.) Homer Jackson knows that these oranges are of a quality to meet the exacting regulations required by the Florida Citrus Commission.

These standards for quality in citrus products are the highest in the world. This is important to you and your patients because juice made from the best oranges will be nutritionally best for your patients. It will contain abundant amounts of vitamin C and rich, natural fruit sugars.

It's good nutrition to encourage people to drink orange juice. It makes good sense to persuade them to drink orange juice that you *know* tastes good, has the right sugar-acid ratio, and is packed full of nutritionally important vitamin C.

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DORNWAL® HAS BEEN CALLED "THE GENERAL TRANQUILIZER FOR GENERAL PRACTICE."

Suppose the physician visiting this patient finds that he has to be hospitalized. Certainly he wants an alert but not excited fellow who can respond to the history and physical on admission. Depending on the condition, of course, the thing to do is to give the patient one or two tablets of Dornwal before he ever leaves his home.

Dornwal will calm the patient but won't make him drowsy or give him feelings of depersonalization. And what's more, while Dornwal most assuredly tranquilizes, it won't interfere with most other medications that your subsequent examination or laboratory studies may indicate.

Since every man in general practice encounters such situations almost daily, it makes good sense to keep some tablets in one's bag, doesn't it? We will be glad to send you a supply.

Dosage: One or two 200 mg. tablets three times a day. Children, age 6 to 16, one or two 100 mg. tablets two times a day. Administration limited to three months' duration.

Supplied: 200 mg. yellow scored tablets, and 100 mg. pink tablets, each in bottles of 100 and 500.

P.S. For the "Genericist", Dornwal is amphenidone

No absolute contraindications to the use of Dornwal are known. There have been no reports or evidence of habituation, addiction or drug tolerance in animal or clinical studies. Dornwal is relatively free from untoward effects when administered at recommended dosages.

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bership for 36 years, and he was also a member of the American Medical Association.

Surviving are the widow, Mrs. Sallie Groover Greene, and one son, Jimmy Greene, both of Perry; one daughter, Mrs. Robert E. Lassiter Jr., of Lake Wales; three sisters, Mrs. C. F. Roberts, of Fort Gaines, Ga., and Mrs. J. C. Balkcolm and Mrs. Mamie Wilson, of Blakely, Ga.; and four grandchildren.

Henry Lester Tippins

Dr. Henry Lester Tippins of Miami died on Nov. 12, 1960 in that city. He was 72 years of age. Burial took place in Claxton, Ga.

Born in Daisy, Ga., in 1888, Dr. Tippins received his medical schooling at the Atlanta College of Physicians and Surgeons, now Emory University School of Medicine. He was awarded the degree of Doctor of Medicine by that institution in 1913. He engaged in the private practice of medicine in his native state for a number of years before coming to Florida 21 years ago. He moved from Baxley, Ga., to Miami in 1940 and entered the practice of pediatrics. Despite serious chronic illness, he carried on an active practice through the years although for some eight or 10 years he was so severely handicapped that he could see only a few patients occasionally in his home. He was a thirty-second degree Mason and a deacon in Miami's Central Baptist Church.

Dr. Tippins was a member of the Dade County Medical Association and the Florida Medical Association. He also held membership in the American Medical Association and the Florida Pediatric Society.

Survivors include the widow, Mrs. Bonnie Tippins, of Miami; a son; a daughter; four brothers, and five sisters.

Robert Raines Harriss

Dr. Robert Raines Harriss died at his residence in Hollywood on Nov. 19, 1960, after a prolonged illness. He was 53 years of age.

Dr. Harriss was born in Blakely, Ga., on Nov. 18, 1907, and was graduated from Blakely Union High School as valedictorian of his class. He received his academic schooling at Emory University and was awarded the A.B. degree, cum laude, in 1928. For his professional training he attended the Johns Hopkins University School of

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Medicine, receiving his M.D. degree in 1932. After serving an internship at the Harriet Lane Home for Invalid Children in Baltimore, he was a resident in pediatrics at Bellevue General Hospital in New York City from 1933 to 1935. He then entered the private practice of pediatrics in Hollywood, where he was associated with Dr. Elbert McLaury and was a co-founder of the Hollywood Clinic and Hospital. He was on the staff of the Broward General Hospital and the South Broward Memorial Hospital. Locally, he was a member of the First Baptist Church and a director of The Home Federal Savings and Loan Association.

A member of the Broward County Medical Association, Dr. Harriss had for 26 years held membership in the Florida Medical Association. He was also a member of the American Medical Association, the Southern Medical Association, and the Florida Pediatric Society, and was a fellow of the American Academy of Pediatrics.

Dr. Harriss is survived by his widow, Mrs. Mary Jane Harriss, of Hollywood; and a brother, A. D. Harriss, of Blakely, Ga.

NEW MEMBERS

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BOOK REVIEWS

Fundamentals of Clinical Hematology. By Byrd S. Leavell, M.D., and Oscar A. Thorup Jr., M.D. Pp. 503. Illustrated. Price, $10.00. Philadelphia, W. B. Saunders Company, 1960.

This comprehensive, but not encyclopedic, volume serves the diagnostic and therapeutic needs of the internist or family physician who is not a hematologist. The authors begin with a clear description of the morphology and function of blood cells and then discuss the problems of anemia. They present in detail the 18 major types of anemia and a well rounded picture of the problems involved in polycythemia. Description of blood coagulation and hemostasis leads into sound and clinically meaningful advice on the 17 major disorders of clotting. Basic information is set forth on mechanisms of production of white cells—their function, normal values, physiologic variations, and variations associated with disease. Specific disorders of leukopoiesis are taken up with particularly thorough coverage of infectious mononucleosis. Two chapters deal with leukemia and malignant lymphoma and their treatment. The final chapter presents clearly and succinctly a description of office and hospital laboratory procedures useful in hematology. The entire book is well documented with some 1,500 up-to-date references. Photographs and diagrams are carefully chosen to acquaint the reader with normal appearances, significant abnormalities, and important metabolic processes. Case histories are used where they help demonstrate principles of diagnosis and management. This is a useful working volume in understanding the more common blood disorders, helpful to practicing physician and student alike.

Anatomy. *A Regional Study of Human Structure.* By Ernest Gardner, M.D., Donald J. Gray, Ph.D., and Ronan O'Rahilly, M.Sc., M.D. Pp. 999. Illus. 632. Price, $15.00. Philadelphia, W. B. Saunders Company, 1960.

This unusual anatomy text is boldly designed to meet the changing needs of today's students. It also affords the practitioner a new appreciation of basic anatomy for the subject is portrayed as an area in which knowledge is always advancing. The approach of the volume is regional. Text and illustrations follow along the natural, main subdivisions of the body, directly correlating with the student's dissection room experience. Systemic considerations are included where pertinent in the regional discussions. Surface, radiographic, and living anatomy are beautifully pictured and explained. The 568 unusual drawings demonstrate difficult anatomic relationships not readily apparent in the "realistic" atlas. Paris Nomenclature of 1955 is used throughout, with older synonyms noted at least once. Among the helpful features are many carefully chosen references and a separate glossary of eponyms.

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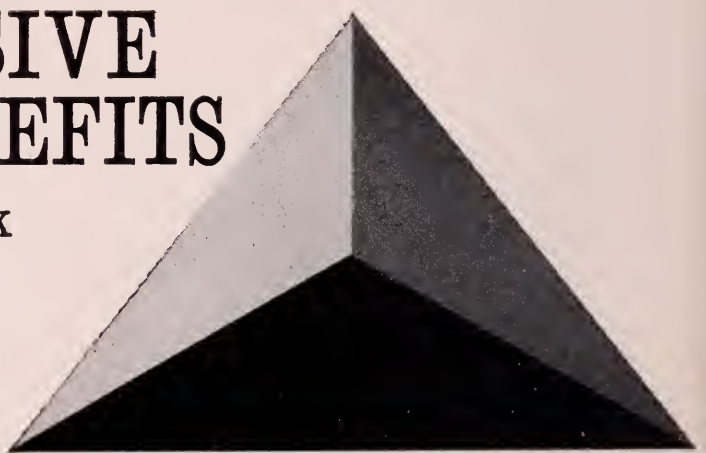
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A Doctor Enjoys Sherlock Holmes. By Edward J. Van Liere. Pp. 141. Price, $3.00. New York, Vantage Press, 1960.

This brief series of essays makes interesting reading, although there is some tendency to redundancy. This possibly can be explained by the fact the essays were written over a period of time under varying circumstances. Dr. Van Liere, Dean of the School of Medicine at West Virginia University, is a true member of the Baker Street Clan and evinces considerable knowledge of the subject. He spends, however, as much or more time on Dr. Watson as he does on Holmes, possibly understandably so, as it is physician writing about physician. He almost writes the essays in a biographical vein. In these pages, he covers the weather, anatomy, traumatic conditions, surgical and medical conditions, endocrinology, botany, chemistry, genetics, zoology, physiology, pharmacology and therapeutics in general practice. Reading this volume will certainly rekindle an interest in the works of Conan Doyle's heroes.

The print is clear, but several gross compositor's errors were noted in the book.

W. D. S.

Encyclopedia of Medical Syndromes. By Robert H. Durham, M.D., F.A.C.P. Pp. 628. Price, $13.50. New York, Paul B. Hoeber, Inc., 1960.

Syndromes, in one sense of the word, have come to be rather a nuisance. Even the definition of this term is questionable. Some believe it to mean a pattern of pathological findings while others associate it with a mosaic of physiological signs and symptoms. As long as syndromes remain *descriptive* most physicians appreciate them, but disregard is exhibited when the term becomes *eponymic,* that is, bearing the name of an individual. Not belittling our medical ancestors because many of these pioneers are deserving, but it becomes ridiculous when every Dr. Where and Dr. Elsewhere starts sindreaming of syn-droming. There is no single text or volume that could possibly be current on syndromes because with the dawn of each morning a new syndrome is born. As long as doctors have names there will be syndromes. There should start a new specialty specific for these physicians and call it syndromic medicine. Regardless, syndromes are here to stay, and apparently the author in this faith decided to help the matter by attempting to correlate these constant patterns into some form for the sake of clarity. There is little doubt that many years were spent in preparing this interesting encyclopedia of over 1,000 recognized syndromes. Each is presented with descriptions, etiology, signs and symptoms, pathology, therapy and prognosis. He has cross-indexed them for rapid location and included synonyms for comparative reasons. The index has been arranged in a manner to be of great help. For those who encounter the problem of being harrassed regarding syndromes, especially the medical student and resident trainees, this dictionary covers the subject masterfully.

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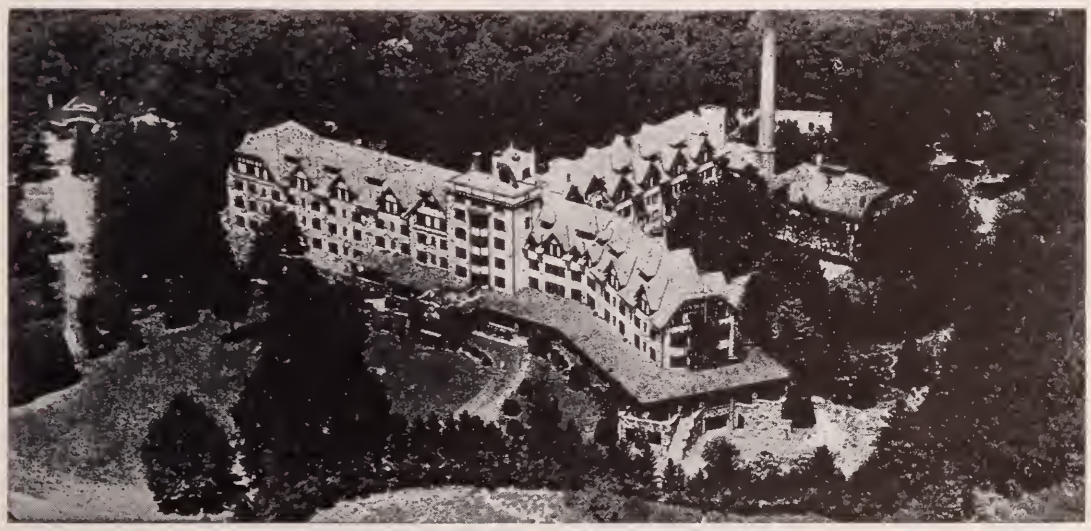
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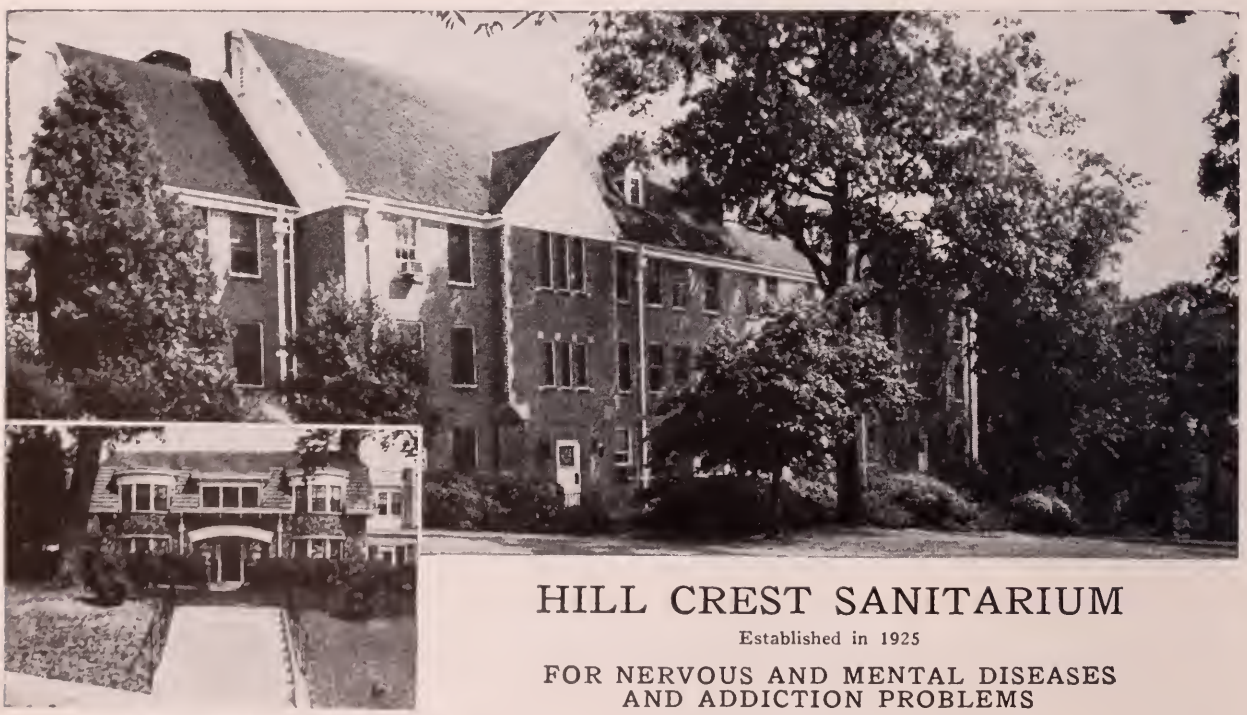
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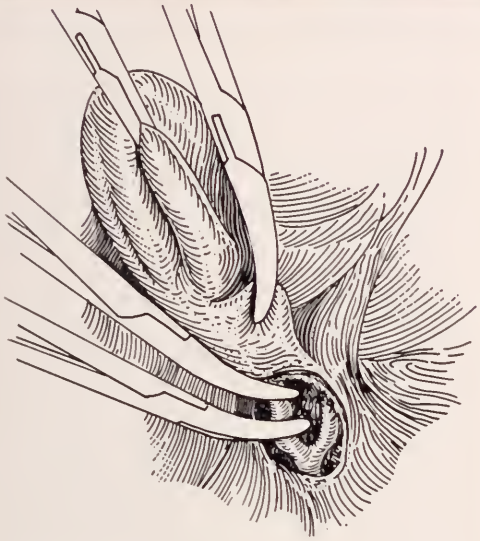
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SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL MEMBERS
Alachua	Raymond J. Fitzpatrick, Gainesville	Richard E. Perry, Gainesville	2nd Tues.	85
* *Bradford, Gilchrist, Union*				
Bay	John J. Hollomon, Panama City	A. Ralph Monaco, Panama City	1st Tues.	31
Brevard	Willard H. Bennett, Titusville	Frederick H. Lucas, Cocoa Beach	1st Tues.	73
Broward	Burns A. Dobbins Jr., Ft. Lauderdale	Frederick W. Fisher, Ft. Lauderdale	4th Tues.	265
Charlotte	Carl N. Reilly, Punta Gorda	Stephen R. Roddy, Punta Gorda	2nd Tues.	7
Clay	William A. Mulford, Green Cove Spgs.	Joseph G. Ritch Jr., Orange Park		10
Collier	Loral F. Gwaltney, Naples	Ethel H. Trygstad, Naples	4th Tues.	14
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.	12
* *Baker*				
Dade	Willard L. Fitzgerald, Miami	George W. Robertson III, Miami	1st Tues.	1063
DeSoto-Hardee-Glades	Harold S. Agnew, Arcadia	Elmer J. Schmierer, Arcadia	1st Tues.	15
Duval	Sidney Stillman, Jacksonville	Robert J. Brown, Jacksonville	1st Tues.	358
Escambia	P. G. Batson Jr., Pensacola	Vernon L. Smith, Pensacola	2nd Tues.	118
Franklin-Gulf	William F. Wager, Port St. Joe	Henry I. Langston, Apalachicola	Last Wed.	7
Highlands	Samuel A. King, Avon Park	Claude B. Henderson, Avon Park	3rd Mon.	13
Hillsborough	Herbert B. Lott, Tampa	Frank A. Massari, Tampa	1st Tues.	265
Indian River	Phil D. Morgan, Vero Beach	Walter W. McCorkle, Vero Beach	2nd Tues.	14
Jackson-Calhoun	Terry Bird, Blountstown	Francis M. Watson, Marianna	Quarterly	17
Lake	Lawton F. Douglass, Umatilla	Raymond A. Debo, Eustis	1st Wed.	35
* *Sumter*				
Lee-Hendry	Jack C. W. Warnock, Ft. Myers	Richard W. Plummer, Ft. Myers	3rd Mon.	38
Leon-Gadsden-Liberty-Wakulla-Jefferson	Nelson H. Kraeft, Tallahassee	David J. McCulloch, Tallahassee	1st Mon.	78
Madison	Julian M. Durant, Madison	A. Franklin Harrison, Madison	1st Tues.	6
Manatee	Warren G. Darty, Palmetto	C. Sumner Quimby, Bradenton	2nd Tues.	39
Marion	Herbert M. Webb Jr., Ocala	Keith H. Knorr, Ocala	3rd Tues.	33
* *Levy*				
Monroe	William R. Ploss, Key West	Joseph L. G. Lester Jr., Key West	1st Thurs.	18
Nassau	Henry B. Dickens Jr., Fernandina Bch.	John B. Britton, Fernandina Beach	1st Thurs.	11
Orange	Norman F. Coulter, Orlando	Truett H. Frazier, Orlando	3rd Wed.	236
* *Osceola*				
Palm Beach	William H. Proctor, W. Palm Beach	Herman Baxt, W. Palm Beach	4th Mon.	195
Pasco-Hernando-Citrus	William H. Walters Jr., Lacoochee	W. Wardlaw Jones, Dade City	2nd Thurs.	19
Pinellas	Walter H. Winchester, Dunedin	Whitman C. McConnell, St. Petersburg	1st Mon.	316
Polk	John E. Daughtrey, Lakeland	Albert G. King Jr., Lakeland	2nd Wed.	129
Putnam	Walter W. Weigel, Palatka	James R. Sayers, Palatka	2nd Tues.	15
St. Johns	Reddin Britt, St. Augustine	James R. Kennedy, St. Augustine	3rd Tues.	17
St. Lucie-Okeechobee-Martin	John D. Browning, Fort Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.	30
Sarasota	George A. Bishopric, Sarasota	Harry O. Specht, Sarasota	2nd Tues.	89
Seminole	Clyde F. B. Smith, Sanford	George H. Starke (Col.), Sanford	2nd Tues.	18
Suwannee-Hamilton-Lafayette	Hugo F. Sotolongo, Live Oak	William P. Blackmon, Jasper	1st Sat.	6
Taylor	John A. Dyal Jr., Perry	Charles M. Roberts, Haines City	Last Fri.	5
* *Dixie*				
Volusia	C. Robert DeArmas, Daytona Beach	Thomas W. Ayres, Daytona Beach	2nd Tues.	99
* *Flagler*				
Walton-Okaloosa-Santa Rosa	Allen A. Enzor, Crestview	Albert B. Russell Jr., Ft. Walton Beach	3rd Tues.	38
Washington-Holmes	Walter H. Shehee, Chipley	John T. Grace, Bonifay	Quarterly	4
			Grand Total	3,841

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Source: Farris, J. M., and Smith, G. K.: M. Clin. North America *43*:1133 (July) 1959.

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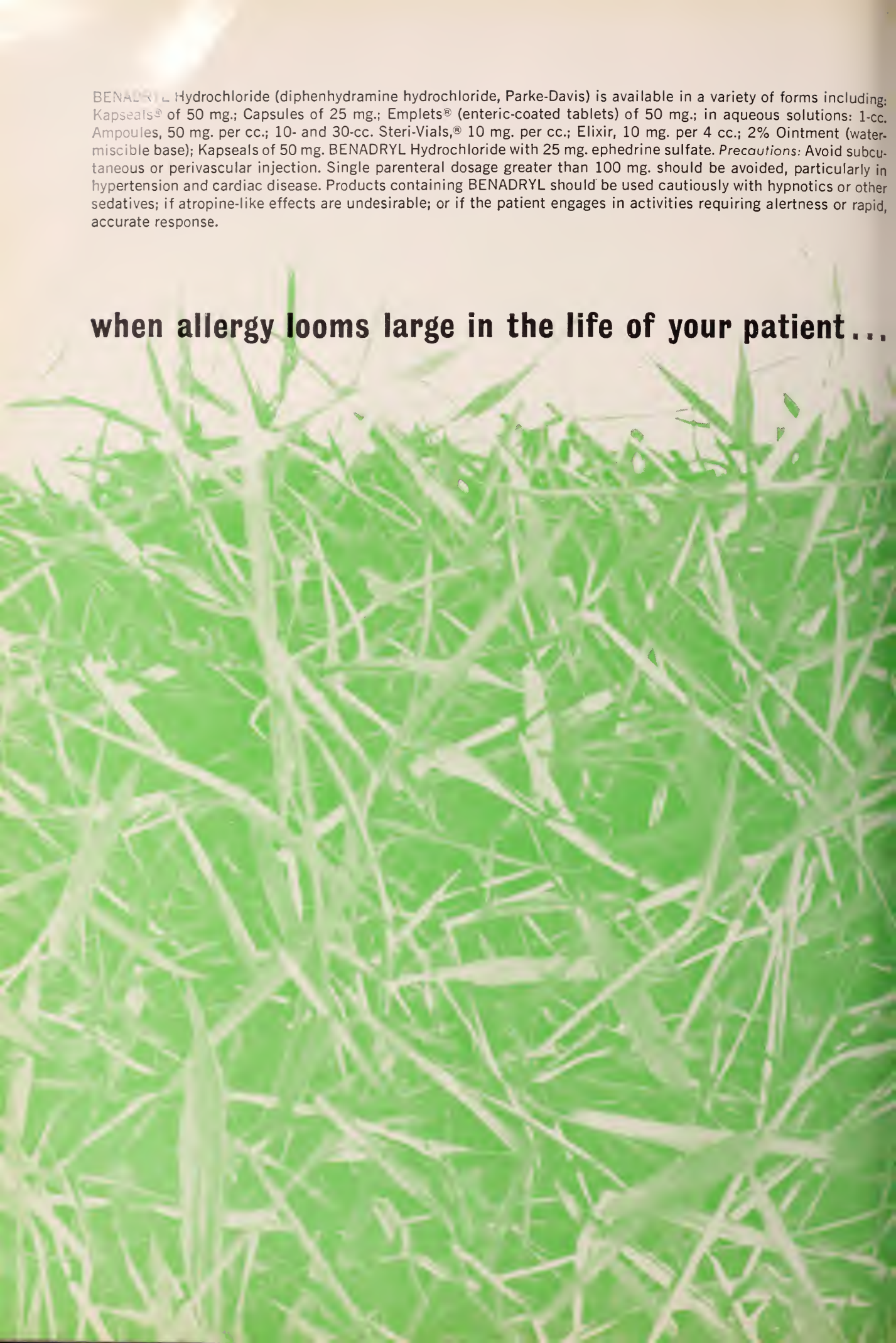
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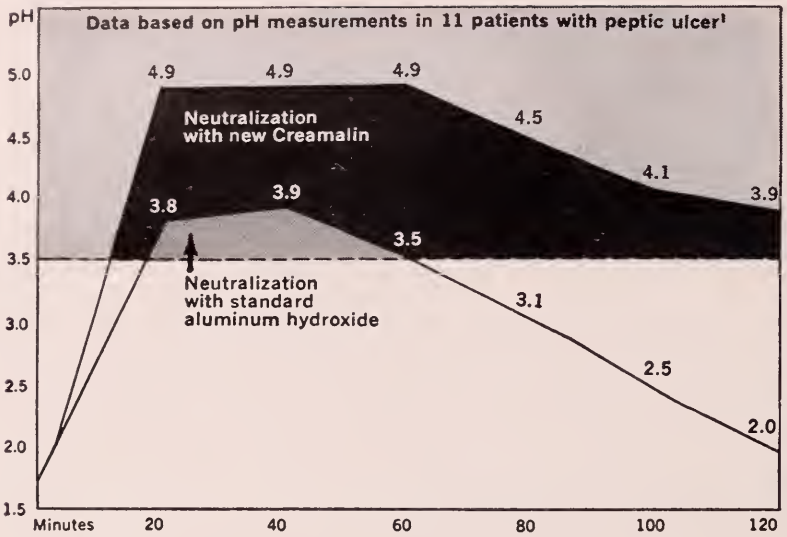
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1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

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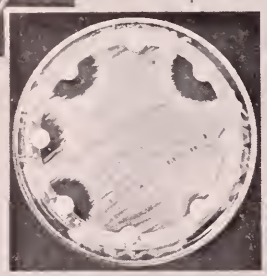
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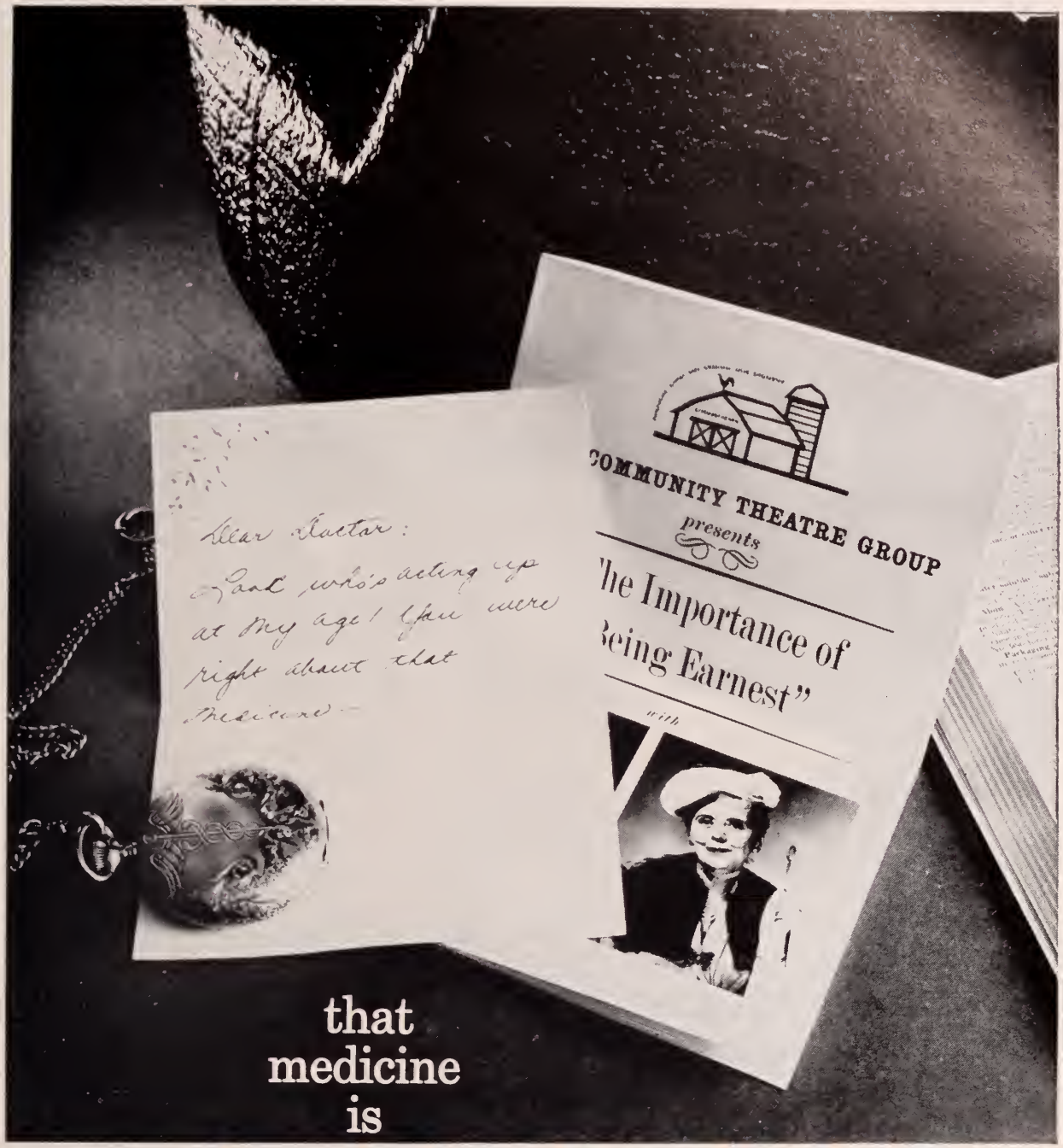
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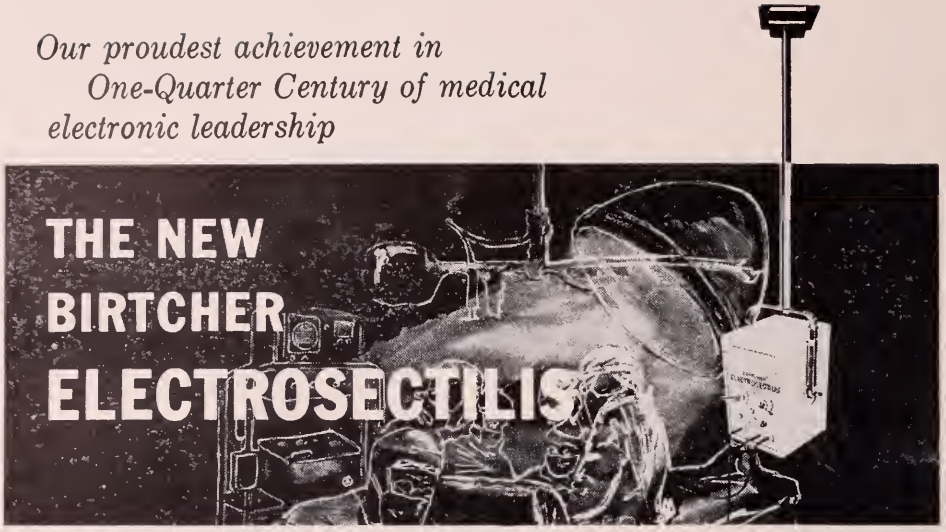
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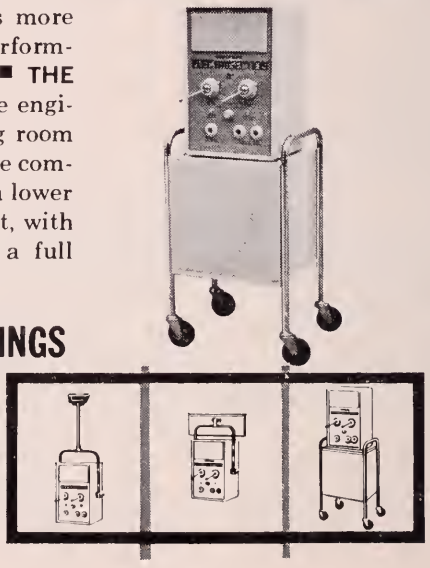
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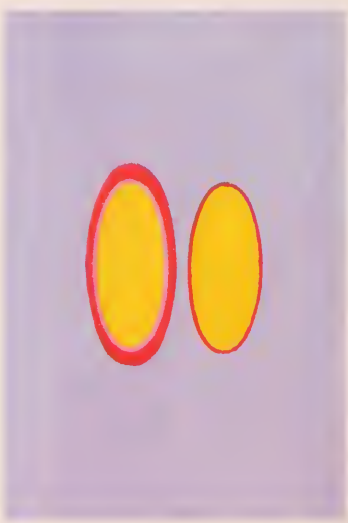
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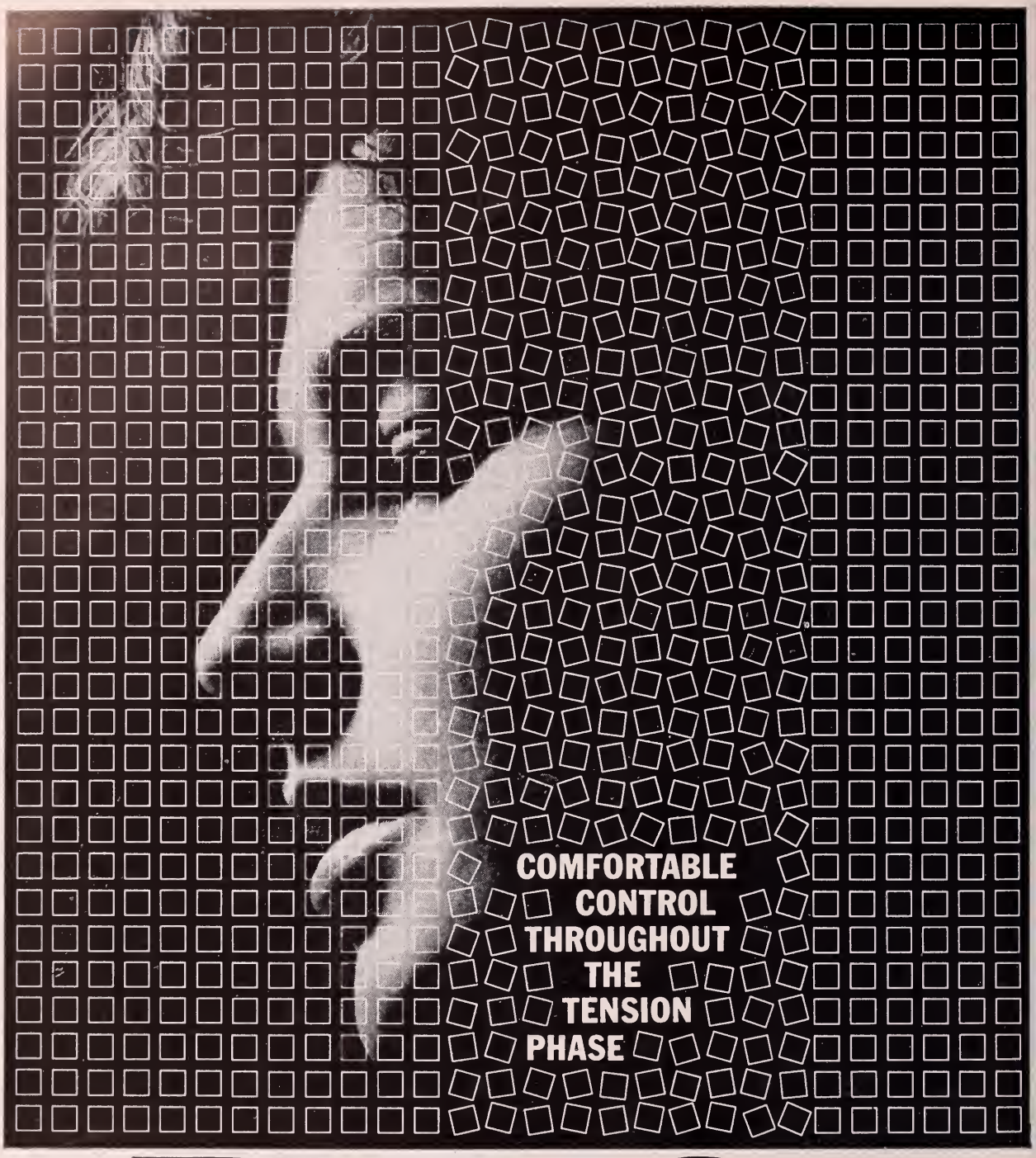
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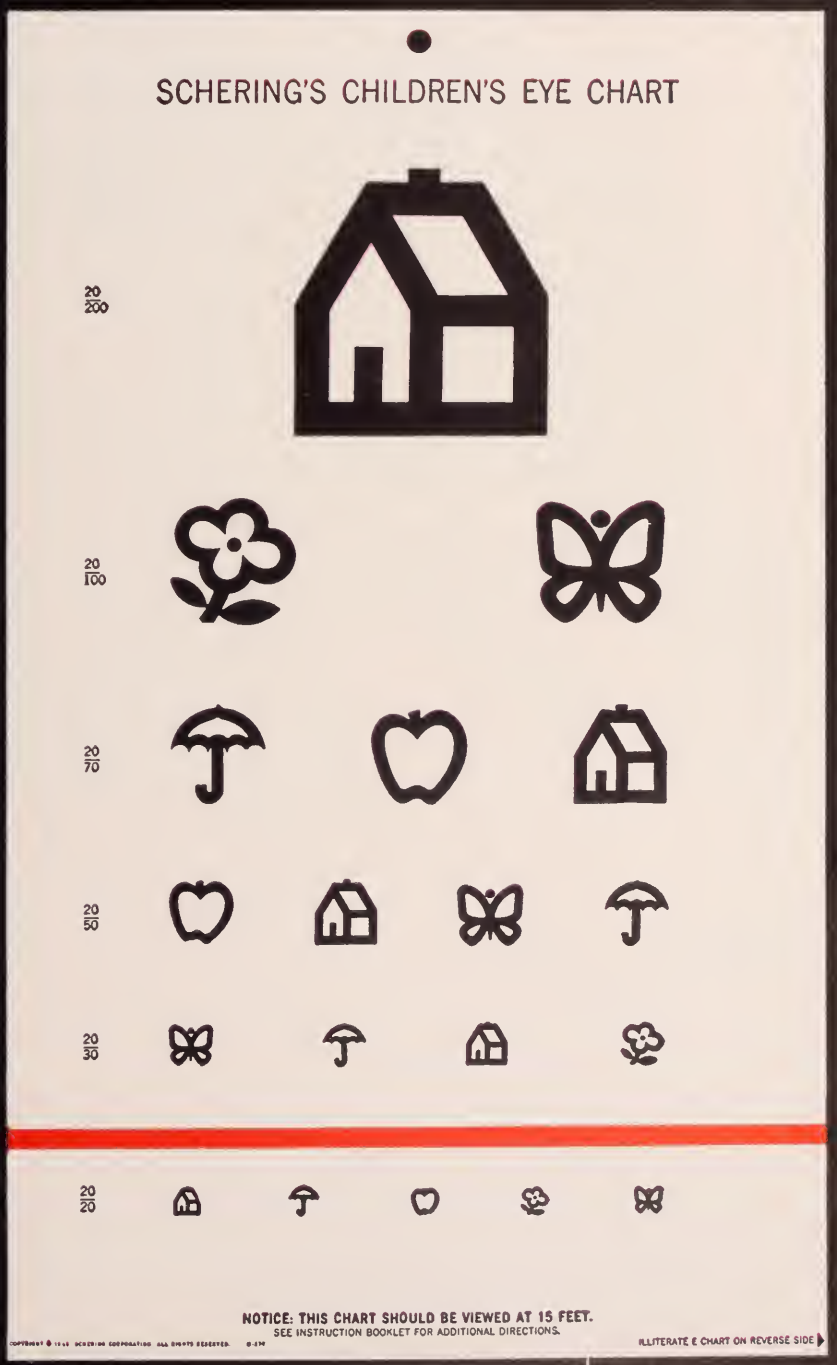
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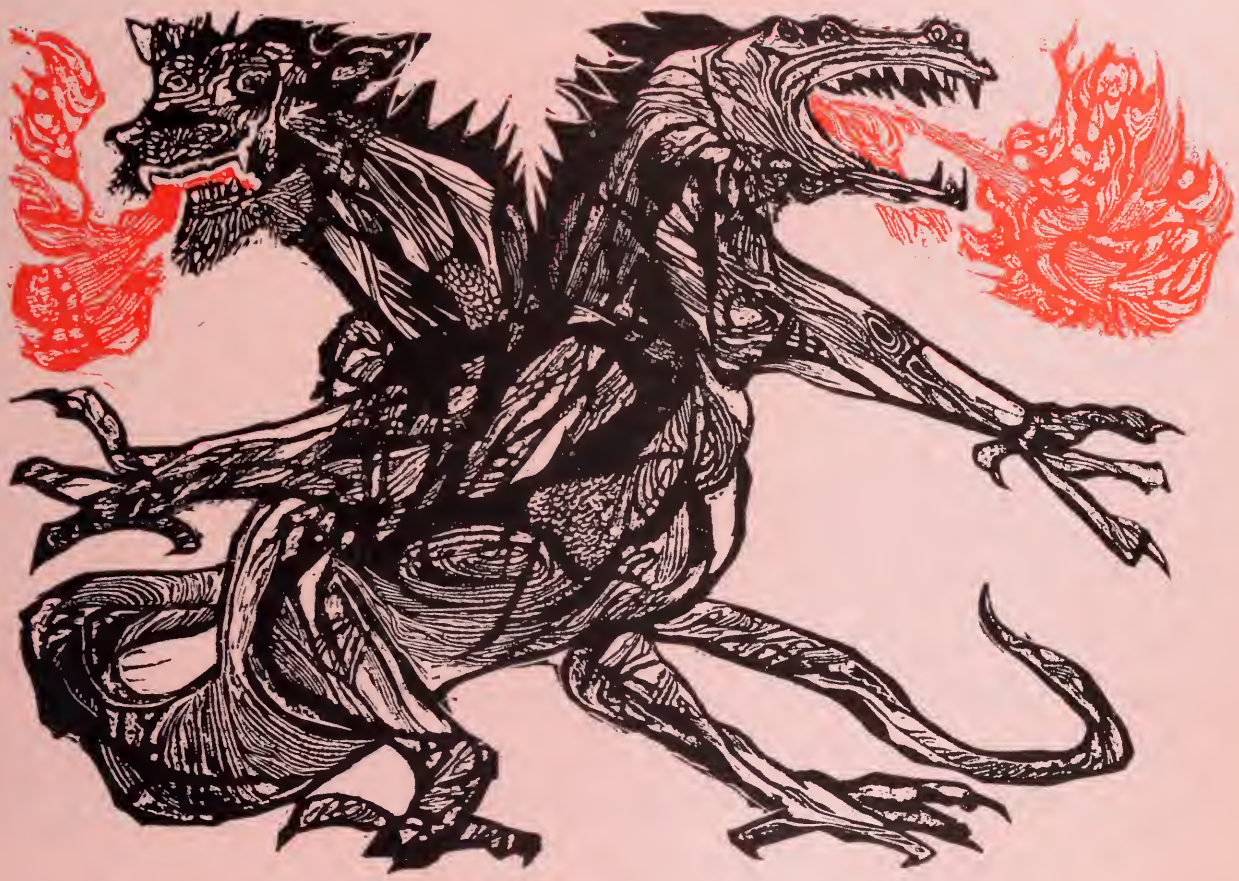
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Adults—1 to 2 teaspoonfuls (preferably at mealtime) three times daily.

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OF THE
FLORIDA MEDICAL ASSOCIATION
Volume XLVII, No. 11, May, 1961

The Treatment of Open Hand Injuries

JOHN L. BELL, M.D.
CHICAGO

"Acute injuries of the hands began to receive better treatment only after infections were better understood and after their care was hoisted out of the realm of the neophyte and minor surgery into that of the experienced surgeon." Michael L. Mason.[1]

Open injuries of the hand compose a major segment of trauma in industry and in the home. Treatment begins with first aid and is not completed until maximal rehabilitation has been attained. Initial wound care is by far the most important step in treatment. A guiding principle in management of open injuries is to secure healing without infection and with minimal inflammatory reaction.

Formation of excessive scar tissue is the greatest threat to functional return in surgery of the hand. At all stages of care the surgeon has to deter factors which increase scar formation, namely, sepsis, devitalized tissues, foreign bodies, hemorrhage and edema. Careless operative technique causes additional tissue damage and compounds the injury.

There are numerous types of hand injuries ranging from simple skin lacerations to extensively destructive and mutilating injuries. Division of open injuries into "tidy" and "untidy" wounds, as suggested by Rank and Wakefield,[2] is both convenient and practical. Treatment and prognosis are influenced by the extent of damage to various tissues. Most household accidents from knives or glass cause "tidy" injuries in which damage is confined closely to the path of the wounding agent.

"Untidy" injuries are characterized by widespread destruction, the result of tearing or crushing forces. Typical examples are wounds caused by explosives, power tools, and farm and industrial machinery. The wounds are usually multiple and have a jagged appearance. Comminuted fractures and extensive losses of tissue are common. Defects of covering tissue may present a greater problem than injury to deeper tissues.

The management of open hand injuries is based upon certain principles of care which apply to all wounds. It is primarily important to establish a working diagnosis and lay out a plan of care before proceeding with an initial operative procedure. If such is not done, a nerve, tendon or severe vascular injury may be treated mistakenly as a trivial wound.

First Aid

First aid should be simple and limited to control of hemorrhage, protection of the wound from additional bacterial contamination and avoidance of further tissue damage. Elevation of the part and compression over the wound usually suffice to control bleeding from the hand. A tourniquet is seldom necessary and is not without danger. Bleeding is accentuated by a tourniquet which impedes venous return but fails to stop arterial flow. Severe and at times irreparable damage may be inflicted upon underlying neurovascular structures if a tourniquet is employed without

Assistant Professor of Surgery, Northwestern University Medical School, and attending surgeon, Passavant Memorial Hospital, Chicago, Ill.
Read before the Florida Medical Association, Eighty-Sixth Annual Meeting, Jacksonville, April 11, 1960.

regard to the degree of pressure at the site of application.

Ideal first aid care consists in application of a resilient compression dressing to a hand immobilized in the functional position by a splint. Local applications of ointments and antiseptic or antibiotic solutions and powders have no place in emergency care of open wounds.

History

When the patient arrives at a location where definitive treatment is possible, a history should be obtained. It should include facts about the circumstances and nature of injury, first aid care, and general health of the patient. From this information the surgeon can estimate the probable degree of contamination and extent of tissue damage. In some injuries the scope of treatment and choice of anesthesia are determined by the patient's general health and physical status prior to the accident.

The "time lag" following injury is of importance, for it is known that bacteria introduced into wounds require a certain amount of time to propagate and invade tissues. Although antibiotic therapy has possibly prolonged the "golden period," blind reliance must not be placed upon any agent to give reckless license in surgery.[3]

Some wounds are inoculated with such highly invasive bacteria that repair of injured structures or primary wound closure is contraindicated. Injuries contaminated initially by oral and intestinal microorganisms are typical examples. Wounds incurred in barnyard dirt are always suspect, and careful judgment is required as to the extent of initial surgery permissible.

Most industrial accidents are not associated with a high degree of initial bacterial contamination although the workingman's hand is grossly soiled by grease, ink, metal or carbon. In these injuries there is always a possibility of severe secondary contamination from oronasal sources due to improper first aid or inept attempts at surgical intervention by inexperienced attendants.

The nature of injury provides information which helps the surgeon assess the degree of damage to tissues. Neatly lacerated wounds from sharp objects are different from crushing, tearing and degloving injuries. In the latter group, tissues are torn from their blood supply or are crushed, and those which may be expected to survive have a reduced capacity for healing and combating contamination.

Patients should be questioned regarding other disease, allergy and drug sensitivity. Complications due to diabetes, cardiovascular or pulmonary disease, and drug reaction constitute a threat to survival. If general anesthesia is contemplated, the patient's stomach must be empty to avoid aspiration of vomitus.

Examination

Examination of the hand and a comprehensive examination of the patient are essential to establish a proper preoperative impression of the entire situation. Injuries in other anatomical locations may demand priority care, and detection of certain disease processes may influence the treatment of the hand injury.

Examination of every open wound should be carried out by use of the strictest aseptic precautions. Inspection provides valuable information, especially in children too young to cooperate with examination. An open wound should never be probed to try to establish the continuity or dissolution of anatomical structures.

For adults and older children with "tidy" injuries, an accurate determination of functional loss is made without disturbing the wound. Preoperative diagnosis of nerve and tendon division is achieved by performing a few simple tests. Each digit is tested for active flexion and extension of its phalanges. Integrity of intrinsic muscles supplied by the median and ulnar nerves is established by the ability to oppose the thumb and abduct fingers from the midline. Sensory loss over the distribution of the median, ulnar and radial nerves is determined by the absence of feeling to pin prick or light touch.

Preoperative diagnosis of nerve or tendon injuries in young children taxes the ingenuity of any surgeon. No attempt should be made to examine a struggling child. Wait until the child is quiet and then observe the posture of the relaxed hand. Abnormal positions of digits are strongly indicative of tendon division, but nerve injuries are suspect by location of the surface wound.[4]

The need for urgent surgical intervention in mutilating trauma of the hand or any of the parts is apparent after a first glance. In "untidy" injuries little information is gained by prolonged preoperative testing or inspection of wounds. Roentgenologic examination, however, is essential to determine the integrity of the skeletal framework, since one cannot rely upon findings during operation. During preoperative preparation of the patient, the hand should be placed upon a splint in

the position of function, a resilient compression dressing applied, and the hand elevated. For "untidy" injuries the final assessment of tissue damage is determined only after anesthesia and wound cleansing have been completed.

Operative Care

Operative treatment of hand injuries, even the most trivial, should be performed under operating room conditions. This does not mean that all the equipment of a major operating setup is always needed, but any wound must be accorded the same aseptic care whether it is treated in an emergency room or a doctor's office. If a correct working diagnosis has been attained, an experienced surgeon does not attempt an extensive reparative procedure in an ill-equipped operating area.

A bloodless field is essential during many operations for hand injuries, and is obtained readily by application of a blood pressure apparatus to the arm. In normotensive patients a pressure of 280 mm. Hg is safe and sufficient to enable the surgeon to identify delicate structures encountered during an operative procedure. To avoid venous congestion the extremity should be elevated for at least one minute prior to rapid inflation of the cuff to a pressure which prevents arterial bleeding.

Anesthesia.—The choice of anesthesia is dependent upon many factors. Superficial wounds are treated with local infiltration of 1 per cent Novocain. Other injuries can be managed on an outpatient basis by combining local, field or nerve blocks.[5] Typical examples are amputated finger tips, extensor tendon injuries on the dorsum of a digit, and small skin defects requiring skin grafts.

For extensive injuries we prefer to employ general anesthesia. If the wound is extensive and general anesthesia is contraindicated, the procedure may be safely performed under brachial block anesthesia. The anesthetic agent is introduced into the arm, and the complication of pneumothorax is thereby avoided. Supraclavicular brachial plexus blocks have not been satisfactory.

Wound Cleansing.—The first step in the operative procedure is to transform an open, contaminated wound into a surgically clean wound. This is accomplished simply by washing and rinsing with bland soap and sterile water. For simple wounds proper cleansing demands 10 minutes, but in complex injuries at least 20 minutes is required to assure a suitable operative field.

After proper preliminary preparation, frequent rinsing of the wounds with sterile isotonic saline solution helps to rid the wound of blood clots and loose debris. Careful cleansing, first of the surrounding area, then of the wound itself, renders the field surgically clean and amenable to exploration, enlargement and dissection.

For most superficial injuries cleansing is performed prior to anesthesia without undue distress to the patient. In extensive injuries, however, anesthesia is necessary for proper preparation of the operative field. Many surgeons prefer detergent agents instead of ordinary bar soap, and there can be little objection to their use. Colored antiseptic reagents should never be used for hand surgery because the masking effect prevents correct assessment of circulation.

Debridement. — Debridement is the foundation of the operative care of any open wound. Its goal is to convert the accidental wound into a surgically clean wound which contains only viable tissues. For most "tidy" injuries all that is necessary is removal of blood clots and foreign bodies and ligation of bleeding vessels. "Untidy" or crushing wounds are associated with extensive tissue destruction, and the process of wound excision is more complex.[6]

Wound excision is an exploratory procedure into all the depths of the wound. Each type of tissue encountered has to be assessed as to its viability. In the hand, skin excision must be performed with care since every viable tag may be needed for closure. Flaps of skin which are severely crushed, whose blood vessels are thrombosed, or which are deprived of blood supply should not be saved.

Obviously devitalized muscle must be removed. Nonviable muscle does not contract, is dark and soft, and does not bleed from a cut surface. Nerve and tendon excision should be minimal. In severe mutilating injuries the only absolute indication for amputation of digits is nonviability.

Bone fragments should not be needlessly sacrificed if there is any connection whatsoever between the bone fragment and the soft tissue. Many extensively comminuted fractures, particularly around joints, may be molded into good position after surrounding soft tissues have been repaired.

Degloving injuries present a real problem in excision because of the temptation to suture the skin back into position. This is always followed by necrosis of the flap and makes later care difficult. Some surgeons utilize avulsed skin as free grafts after defatting its undersurface. We

have had better success, however, with split-thickness skin grafts in acute injuries.

The "blood pressure cuff test" is useful to determine viability of skin flaps. After unquestionable areas of devitalized tissues are excised, the blood pressure cuff on the arm is inflated to 280 mm. Hg pressure for a few minutes and is then released. The surgeon observes the return of color to the part during the reactive hyperemia which follows release of pressure on the arm. Frequently flaps thought to be lifeless show signs of adequate vascularity by a slowly appearing pink color and brisk bleeding from their edges.

DEEP REPAIR. — After debridement a decision must be made concerning the feasibility of repair of deep structures. It is at this phase that the nature and circumstances of the injury, and surgical judgment, influence the course of the procedure. Fractures and dislocations have to be reduced, but repair of tendons and nerves requires more consideration.

Tendon or nerve repair should not be performed if there is any doubt as to primary wound healing. A history of severe bacterial contamination contraindicates primary repair of these structures. In crushing or "untidy" wounds tendon repair is seldom permissible because of lowered tissue vitality over a widespread area. It is essential that all sites of deep repair be covered with normal subcutaneous tissue and skin.

The facilities for repair and the capability of the surgeon are important factors which cannot be dismissed from consideration. Fine suture material, small instruments, good lighting and adequate anesthesia are required for nerve and tendon surgery. Unless the minute details of atraumatic technique are well known, nerve or tendon approximation should not be undertaken at the time of initial wound care.

When there is doubt regarding immediate repair, refrain from extensive reparative surgery; simply cleanse, debride and close the wound. If the wound heals properly, much can be accomplished later by secondary procedures.

A. WOUND ENLARGEMENT

Adequate exposure of nerve and tendon ends through the accidental wound is seldom possible, and additional incisions have to be made to locate them. Incisions are planned carefully and never should cross perpendicular to flexion creases. Midlateral incisions are used to expose flexor structures in digits. In the palm, incisions follow parallel to flexion creases and in the wrist they cross obliquely to either the radial or ulnar border of the forearm. Cruciate enlargement of wounds should be avoided because of severe contractures which follow.

B. NERVE REPAIR

There is still considerable controversy regarding the advisability of primary nerve repair. It is our opinion that results following primary nerve sutures in incised wounds are better than secondary repairs. Digital nerves should be repaired whenever possible. Return of function following a carefully performed initial suture of the motor branches of the median and ulnar nerves cannot be surpassed by a delayed secondary procedure. In the proximal palm and wrist primary suture of the median and ulnar nerves should be performed if at all permissible.

Primary approximation of neatly divided nerves is accomplished without a necessity for marked flexion of the hand or digits. This contrasts with the frequent need for rerouting nerves to overcome long gaps due to scarring and retraction during the interval between injury and secondary repair. There is no disparity in size of neatly severed nerve ends, and it is not difficult to align nerves properly at the time of primary operative care. Sutures have to be placed accurately in epineural tissues. Fine 6-0 ophthalmic silk on a swedged needle is used for nerve approximation which is aided by the surgeon's use of a binocular loupe to magnify the operative field.

C. TENDON REPAIR

With one important exception primary tendon repair should be performed if none of the aforementioned contraindications are present. An accurate end to end suture is accomplished with proper technique. It should be remembered that tendons separate if there is tension at the line of approximation. Only the finest nonabsorbable sutures should be used. Heavy sutures tear the tendon and cause a severe foreign body reaction which leads to a congealed mass of scar tissue at the site of repair.

Management of flexor tendons within the digital sheaths presents a special problem. The area between the proximal portion of the fibrous sheath in the palm and the insertion of the sublimis tendon on the middle phalanx is commonly called "no man's land." In this zone the two sublimis slips and the profundus tendon are encased in a smooth fibrous tube. Results of primary repair are extremely poor in this critical area and until the problem is solved, treatment

is best limited to cleansing, debridement and skin closure. Initial failures at repair jeopardize the chance for functional return even though secondary tendon grafting is performed.

If performed correctly, excellent results may be anticipated after initial repair of flexor tendons severed in the palm, wrist and lower forearm. At these sites an excellent blood supply and abundance of areolar tissue favor healing with minimal adhesions to surrounding tissues. If the line of suture lies beneath the volar carpal ligament, the sublimis tendons should be excised and only the profundus tendons repaired. Attempts to approximate both sets of tendons fail because of the development of a dense cicatrix at the site of repair. Results of primary tendon suture at the wrist and in the forearm are superior to secondary reconstruction, for muscle retraction is difficult to overcome after a few weeks have passed.

It must be remembered that in any flexor tendon division there is a likelihood that the median or ulnar nerve has been severed and should be repaired if circumstances permit any type of deep repair.

In regions distal to the dorsal synovial sheaths severed extensor tendons are repaired without difficulty if soft tissue coverage is adequate. At times it is possible to obtain satisfactory functional results by splinting alone, because the proximal end of a divided extensor tendon retracts very little in comparison to flexor tendons. If extensor tendons have been injured at the wrist level, proximal stumps retract into the forearm and repair can be most difficult.

D. Bone and Joint Injuries

Fractures should be reduced as accurately as possible at the initial operation. Later correction becomes increasingly difficult and functional restoration is either prolonged or impossible. In general, the simplest method for maintaining reduction should be selected. Whatever method is employed for reduction, the guiding principle is to place the injured part in the position of function.

In many instances an extensively fractured hand may be maintained in the position of function by molding it over a universal splint.[7] Recently we have relied more upon the use of fine steel sutures and Kirschner wires to approximate severely comminuted or unstable bone fragments in open injuries. Skeletal traction is seldom applicable or possible for multiple open fractures of the hand.

Open dislocations have to be reduced accurately and are maintained by careful anatomical approximation of capsular structures. To reduce the possibilities for suppurative arthritis, open joints are thoroughly irrigated and covered with capsular or periarticular tissues.

Closure of the Wound. — Primary closure of hand wounds has been emphasized repeatedly, for an open wound is susceptible to infection. In civilian practice one rarely encounters a wound which cannot be closed primarily, provided that early adequate cleansing and debridement have been done. In wounds seen 18 to 24 hours after injury in which adequate previous care has been rendered, cleansing and debridement are carried out. Deep repairs are omitted, and if a primary closure is not advisable, a secondary closure is possible usually by the fourth day.

Closure should be performed if at all possible with normal hand skin for which there is no adequate substitute. During debridement every effort is made to save all viable skin flaps. Many "untidy" injuries, however, are characterized by skin defects too large to permit closure by undermining without undue tension. It is necessary then to consider application of skin grafts and pedicled flaps.

A split-thickness skin graft is by far the most valuable adjunct for closure of large defects. Thick split grafts are procured without difficulty from abundant donor areas on the extremities or trunk. The recipient area must be well vascularized. Full-thickness skin grafts are more applicable for secondary procedures, particularly following removal of scar contractures on the palmar aspect.

Where bones, tendons and joints are bared, free skin grafts are not suitable. Some type of flap is required to protect these structures. One must resist the temptation to replace traumatic flaps so badly torn and contused that they cannot survive.

In many cases a rotation flap can be shifted to cover the traumatic defect. The donor area of the flap is closed with a split-thickness graft. Abdominal flaps may be required if the defect is too large to permit closure by combining use of local shifts of tissue and free grafts.

Cross-finger flaps are useful to cover defects on the volar aspect of digits. The dorsal skin is well vascularized, and generous flaps can be raised and transferred to an adjacent digit with confidence. The dorsal donor site is covered by a free graft.

DRESSINGS AND SPLINTING. — An integral part of the initial procedure is application of a purposeful dressing. An improperly applied dressing may ruin a well performed procedure. A voluminous compression dressing deters venous congestion and edema. Although it helps control capillary oozing, it is not a substitute for careful hemostasis. Digits should always be separated by gauze to avoid maceration and local pressure necrosis. All bony prominences should be padded adequately, and the compression effect of the dressing should be distributed over a wide area. There must be no areas of constriction.

For extensive crushing injuries, fractures and burns the hand is placed on a splint in the position of function. After nerve or tendon repair the hand has to be positioned so that forearm muscles are relaxed and tension at the suture line is thereby avoided. Flexor tendon or nerve repairs require flexion of the hand at the wrist, and after extensor repairs an extended position is required. Postoperative elevation of the hand and rest of the injured part are essential until healing is complete.

The wound is not inspected postoperatively for four or five days unless some definite indication ensues. If the patient complains of severe pain, never hesitate to change the dressing. Local pressure necrosis and ischemic intrinsic contractures due to constriction are disastrous sequelae which can be prevented by proper dressing techniques and intelligent postoperative observation.

Skin sutures are removed between six and 10 days after operation. Usually compression dressings are not required after the initial dressing change, except for cases in which skin grafting was performed. Following tendon and nerve repair immobilization of the part is required for a minimum time of three weeks but not longer than four weeks.

Obviously not all wounds can be repaired initially, and many hands require one or more secondary procedures to restore optimal function. When reconstructive surgery is necessary, it must be remembered that any chance for successful results is dependent largely upon the adequacy of treatment of the acute injury.

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Glomus Jugulare Tumors
Diagnosis and Management

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A glomus is defined as a small conglomeration of cavernous blood vessels. Glomus jugulare tumor is a term designating a tumor arising from glomus bodies located in the adventitia of the dome of the jugular bulb or along the course of the branches of the tympanic branch of the glossopharyngeal nerve and the auricular branch of the vagus nerve.

Guild[1] first described the glomus jugulare in 1941 and elaborated on the subject in 1953. In 1945, Rosenwasser[2] reported a carotid body tumor of the middle ear and mastoid, suggesting it could have developed in the glomus jugulare described by Guild. Numerous cases of glomus jugulare tumors have subsequently been described in the literature. Prior to the observations of Rosenwasser and Guild, these tumors were reported as endothelioma, hemangioendothelioma, and angioendothelioma. They are still of sufficient rarity to warrant relating my experiences with three cases of microscopically diagnosed glomus jugulare tumors and two cases clinically suggestive but not microscopically proved.

In a study of the histologic sections of 88 human temporal bones, Guild[1] noted an average of slightly less than three glomus bodies per ear. More than half of these were in the adventitia of the dome of the jugular bulb. In approximately one fourth of the ears studied, a glomus formation was present in the mucosa of the cochlear promontory along the course of the tympanic plexus. A fifth of the bodies were in the osseous canal through which Jacobson's nerve enters the middle ear from the jugular fossa (fig. 1). The bodies were located superior to the promontory near the continuation of Jacobson's nerve into the lesser superficial petrosal nerve. They were also present along the auricular branch of the vagus (Arnold's nerve) as far peripherally as the descending facial canal (fig. 2). No constancy was observed in the location of these bodies.

Guild[1] attributed the differences in clinical symptoms and apparent site of origin of these tumors to the difference in location as shown by the variety of locations of the normal glomus bodies. He described the glomus jugulare as an ovoid body about 0.5 by 0.25 mm. in diameter. Microscopically the tiny masses consist of blood vessels of capillary and precapillary caliber with numerous epithelioid cells between the vessels. He noted a microscopic similarity between these bodies and the carotid body. They are both innervated by the glossopharyngeal nerve and receive their blood supply from the inferior tympanic branch of the ascending pharyngeal artery.

LeCompte[3] designated the carotid body, the aortic body or bodies, the glomus jugulare, groups of cells associated with the ganglion nodosum of the vagus, and a similar group of cells associated with the ciliary ganglion in the orbit as being members of a chemoreceptor group. The carotid and cardioaortic bodies seem to be sensitive to changes in the pH and in the carbon dioxide and oxygen tension of the circulating blood, and may be of importance in the regulation of respiration. The function of the glomus jugulare and other members of this group is not known, but because of their resemblance to these bodies, it is thought justifiable to classify them as chemoreceptors. The term chemodectoma has been used synonymously with glomus jugulare tumors because of this classification.

The carotid body has long been considered paragangliomic tissue, which is tissue differentiated from the ectodermal neural tube in embryonic life. The adrenal medulla is made up of paragangliomic tissue. This tissue stains brown with chrome salts, and thus the term chromaffin is derived. The carotid body and glomus jugulare are morphologically similar. They are non-epinephrine-producing and both have the same sensory innervation. Neither takes a chromaffin stain. LeCompte[3] distinguished them from the epinephrine-producing chromaffin tissue associated with the sympathetic nervous system as is seen in the adrenal medulla. The term nonchromaffin paragangli-

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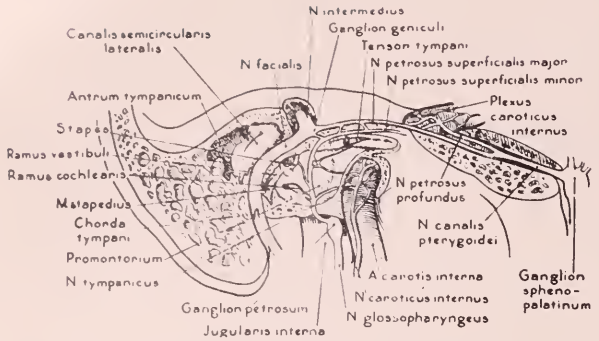


Fig. 1.—The tympanic plexus of nerves: origin, course and relations. (After Lempert, J.,[9] p. 203, fig. 3.)

oma has been used synonymously with glomus jugulare. This multiple classification has added mystery and confusion to this type of tumor.

The glomus jugulare tumor arises in the glomus jugulare. As a rule, it grows slowly but is locally invasive. It was originally believed to be nonmalignant or rarely malignant. Through the years there has been an increasing number of reports indicating it is potentially malignant and demonstrates distant metastasis.[4]

Symptoms

The development and type of symptoms depend on the location of the glomus tumors and the rate of their growth. Taylor[5] classified these tumors as tympanic glomus tumors and jugulare glomus tumors. He thought that the tumors arising in the adventitia of the dome of the jugular bulb are more likely to be invasive than when confined to the middle ear.

The tympanic type is usually first manifest by a reddish-bluish discoloration of the inferior portion of the tympanic membrane. It is usually accompanied early by a conductive deafness. It may be confused with a secretory otitis media. There may be a pulsating type of tinnitus. With increased growth, a sense of fullness, discomfort and pain ensues. An increased hearing loss develops. In the early stages roentenograms reveal no abnormal findings. As this type of tumor enlarges, it will penetrate the tympanic membrane and appear as a vascular polyp in the external canal. Secondary suppuration and discharge will occur at this stage. Patients may have frequent polypectomies before diagnosis is finally made. This condition may easily be confused with suppurative diseases of the middle ear. The tumor may bleed spontaneously. It bleeds profusely when manipulated. Diagnosis is readily made at this stage by a pathologic examination. The biopsy is followed by brisk bleeding, which may be controlled by local packing. As this type of tumor increases in size, facial paralysis, dizziness, and increased deafness may occur, and mastoid roentgenograms may show a slight haziness in the periantral region.

The jugulare type of tumor is more prone to invade bone and grow along the vascular network into the petrous bone. Neurologic symptoms occur as the tumor extends intracranially and involves the nerves of the jugular foramen. Symptoms may be headache, hoarseness, facial paralysis, diplopia, dysphagia, paralysis of the tongue or trapezius muscles, numbness of the face, pulsating tinnitus, and increased deafness. The tumor may manifest itself as a mass in the nasopharynx. In the far advanced stages roentgenograms will show areas of destruction in the mastoid and skull.

Treatment

In the early stage, the tumor may be removed by the Lempert tympanotomy approach. It may be excised locally and the hearing preserved. For more advanced stages, the techniques of Shambaugh[6] may be used. Weille and Lane[7] described

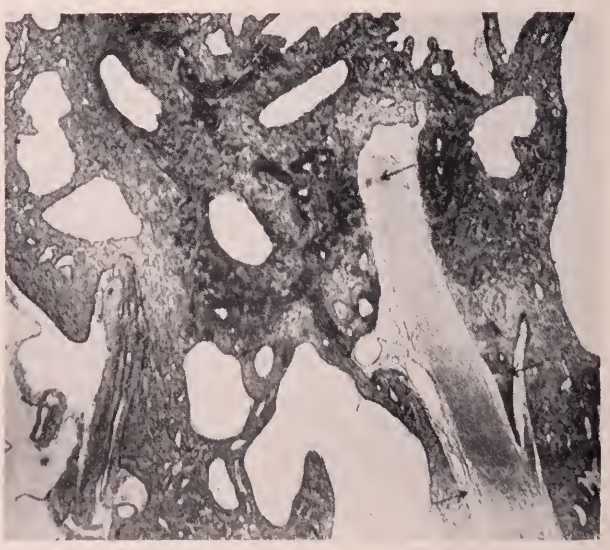


Fig. 2.—Photomicrograph, at a very low magnification, of part of a "vertical" section of a human temporal bone, to show the location of the three glomus formations (indicated by arrows) that are present in this ear in the descending part of the facial canal, in the connective tissue around the facial nerve. Their innervation, however, is from the nerve of Arnold, which crosses the facial nerve in this part of its course. The main stem of the nerve of Arnold can be seen to the left of the facial nerve, somewhat below the middle of the picture. On the right side of the picture of the facial nerve, across from the lower glomus, the origin of the chorda tympani nerve may be seen, also the lower end of its special osseous canal; no glomus formations have been found along the chorda tympani nerve. (After Guild, S. R.,[1] p. 1068, fig. 13).



Fig. 3.—Case 1. Occipital view of the skull. Extensive bone destruction of the petrous apex and mastoid is demonstrated. Some of the changes in the mastoid are the result of the previous operation.



Fig. 4.—Case 1. Posteroanterior view of the skull shows extensive destruction of the right petrous bone, as seen through the right orbit.

the surgical removal of this tumor. They advocated the full exposure of the tumor by removing surrounding bone before attempting to remove the tumor en masse. They described this procedure as removing the patient from the tumor instead of removing the tumor from the patient. This method decreases the amount of blood loss. A radical mastoidectomy is necessary for the more advanced tympanic tumors. Hemorrhage is always a large factor to contend with in this type of surgery. Adequate amounts of blood must be available.

In more advanced cases requiring mastoidectomy, it is not possible to remove every remnant of the tumor. In these cases roentgen therapy should follow surgical measures. In cases with intracranial extension, roentgen therapy is the treatment of choice. Williams, Childs, Parkhill and Pugh[8] advocated the use of surgical and radiation therapy or radiation therapy only in the management of these cases. They suggested the probability of uncomplicated cases being best treated by radiation therapy alone.

Report of Cases

Case 1.—A 53 year old white woman first consulted me on Oct. 1, 1955, complaining of headaches. There was a history of a pulsating noise and aching in the right ear followed in March 1951 by a mastoidectomy in another city for "an ulcer in the mastoid and middle ear," with no aural discharge previously and no facial weakness subsequently. An unsuccessful attempt was made to get a report from the surgeon who operated. In September 1952, her husband slapped her on the right ear. A complete paralysis, a jerking sensation, and a numbness of the right side of the face ensued and persisted; paralysis of the right trapezius and the right sternocleidomastoid muscles also occurred. One and a half years after the operation on the ear, it began to bleed and had bled intermittently up to the time she consulted me. She had experienced no difficulty with the left ear and no previous difficulty with the right ear.

On examination, the tympanic membrane of the left ear appeared normal. On the right side, a postauricular scar was present, and there was a serous discharge around the polypoid tissue which filled the mastoid cavity. Because of its highly vascular nature, a specimen for biopsy was not obtained at this time. Audiometric examination of the right ear disclosed an 85 decibel loss in the speech frequencies, and on masking of the left ear the patient was able to hear only a loud shout in the right ear. A paralysis of the right side of the tongue and the right vocal cord, deviation of the palate to the left side, a diminished to absent gag reflex on the right side of the pharynx, and a numbness of the entire right side of the face were present. A bruit could be heard over the right ear. My clinical impression was that of a glomus jugu-

lare tumor. I recommended that she be hospitalized for a biopsy and requested neurosurgical consultation. Roentgenograms of the skull demonstrated extensive bone destruction involving the right temporal bone. The appearance of this bone suggested to the roentgenologist a malignant condition (figs. 3 and 4).

On October 7, right cerebellar exploration and decompression were carried out by the neurosurgeon. Profuse bleeding occurred throughout the procedure. On retraction of the cerebellar lobe, numerous blackish-appearing blood vessels were seen, forming into a mass in the cerebellopontine angle, which extended from the region of the foramen magnum upwards to the petrous portion of the temporal bone. Extreme vascularity was present. The neurosurgeon thought it unwise to incise the mass. The most likely diagnosis was that of glomus jugulare tumor.

The patient received roentgen therapy, approximately 2,456 r, in 16 visits covering an interval of 21 days. She experienced severe nausea and vomiting during this time, and the latter part of the treatment was so severe that it was deemed wise to interrupt it with the intention of resuming it after an interval of two weeks to two months. The roentgenologist stated that under ordinary circumstances he would have preferred to administer 4,000 to 4,500 r without interruption. When she failed to resume the roentgen therapy and four years had elapsed, fearing she might have succumbed to the illness, I made inquiry. She informed me she was getting along well, had felt much better since the operation and was completely free of the headaches. Examination of the right ear showed some polypoid tissue remaining in the mastoid cavity with serous discharge coming from around the mass. The bruit was still present over the right ear, and the neurologic findings were unchanged.

COMMENT.—Although the diagnosis was not established by biopsy in this case, the clinical impression was that of a glomus jugulare tumor. In view of the very extensive tumor with involvement of the fifth and seventh to twelfth cranial nerves, the response to roentgen therapy is particularly noteworthy. In this type of case this therapy is the treatment of choice for the tumor is entirely too extensive to be removed surgically.

Case 2.—A 66 year old white woman consulted me on March 15, 1958, complaining of intermittent roaring in the right ear of one year's duration associated with an upper respiratory infection at the onset, a pulsating noise occurring with each pulse beat, and some hearing loss in both ears but slightly greater in the right ear. She had experienced no pain nor discharge from either ear.

Examination of the left ear gave negative results. The tympanic membrane of the right ear was mildly retracted with a reddish blue discoloration of the inferior three fourths. The appearance was suggestive of the presence of a tumor in the middle ear. The pharynx, nasopharynx and larynx exhibited no abnormalities, and the orifice of the eustachian tube was carefully visualized with the nasopharyngoscope. Roentgenograms of the mastoids gave negative evidence. No pulsating movement of the tympanic membrane was present although the patient complained of a pulsating noise in the right ear with each heart beat. Audiometric examination demonstrated a mixed deafness bilaterally. The loss for the speech frequencies was 35 decibels in the right ear and 20 decibels in the left ear. My clinical impression was that of an early glomus jugulare tumor. The patient declined a tympanotomy, preferring to consult me at intervals to see if the condition progressed. Examinations in May, June and October of 1958 indicated no change, and although the patient was to return in three months, I have not seen her since.

COMMENT.—This case is probably one of glomus jugulare tumor although this diagnosis was not substantiated by biopsy. Had I seen this condition in a younger person, I would have been more insistent that a tympanotomy be performed. In the early stages this tumor may be eradicated and the hearing preserved. Early diagnostic tympanotomy should be advocated in cases suggestive of tumors of the middle ear.

Case 3.—A 28 year old white woman was examined on May 8, 1958. She complained of pain, a feeling of fullness, and loss of hearing in the right ear of nine weeks' duration. A physician elsewhere had performed a paracentesis which was followed by profuse hemorrhage.

Examination of the left ear gave negative results. The tympanic membrane of the right ear appeared highly vascular and thickened. Because of the inflamed thickened appearance, a myringotomy was carried out; profuse hemorrhage ensued which had to be controlled by local packing. Sclerosis of considerable degree in the antral portion of the right mastoid was demonstrated roentgenographically. Cells of the main portion of the mastoid were well preserved and showed only slight cloudiness compared to a normally clear left side. No destruction of bone was evident (fig. 5).

One week later, polypoid tissue was extruding from the middle ear. On audiometric examination, hearing was normal in the left ear and there was a 25 decibel conductive loss in the speech frequencies in the right ear. I thought that glomus jugulare tumor should be ruled out and recommended exploratory mastoidectomy.

On May 30, I performed a right radical mastoidectomy. The epitympanum was normal in appearance. On elevating a skin flap in the canal and reflecting the tympanic membrane anteriorly, a large tumor was visible filling the middle ear. Pathologic diagnosis of a frozen section was chronic inflammatory reaction. The tissue was extremely vascular, and it was my clinical impression that the mass was a glomus jugulare tumor. In an attempt to eradicate the lesion completely a radical mastoidectomy was performed, and the patient received 1,000 cc. of blood during the procedure. Most of the tumor tissue arose in the posteroinferior portion of the middle ear in close proximity to the descending portion of the facial nerve. The floor of the middle ear was palpated, and there was no exposure of the jugular bulb. It was necessary to leave a small fragment of the tissue posteroinferiorly. The pathologic diagnosis was glomus jugulare tumor (fig. 6).

Postoperatively, the patient was seen in consultation with the roentgenologist. Roentgen therapy was recommended and consisted of a total dosage of 3,000 r. She has experienced no further difficulty, and when she was last examined on Sept. 29, 1959, the cavity was completely healed.

COMMENT.—Frequently it is not possible to remove every remnant of the tumor. Roentgen therapy should supplement surgical measures in such cases. When frozen section fails to demonstrate a glomus tumor in clinically suspicious cases, treatment should be directed as if a glomus tumor were present until the fixed section shows to the contrary.

Case 4.—A 56 year old Negro woman was seen by me on Aug. 18, 1958, in consultation with the referring physician. Seven months previously she had complained of an earache in the left ear with some discharge and she had experienced intermittent pain in this ear since that time. Six weeks prior to my examination, the referring physician had removed polypoid tissue from the ear and he stated that at that time a firm polypoid mass completely filled the external auditory canal. The patient was hospitalized, and the mass was snared off at the level

of the tympanic membrane. Profuse bleeding followed. A pathologic diagnosis of hemangioma was made. Suspicious because of the clinical findings, he requested that the tissue be sent to the Armed Forces Institute of Pathology with a suggested possible diagnosis of glomus jugulare tumor. The diagnosis made there was glomus jugulare tumor.

Examination of the right ear gave negative results. In the left ear a polypoid mass posteriorly appeared to obscure the whole tympamic membrane except far anteriorly. A pulsating serous discharge was present around it, and pulsation of the mass was synchronous with the pulse. No facial weakness was evident. A 75 decibel loss of hearing was present in this ear. Roentgen examination gave evidence of a slight haziness of the left mastoid.

On September 2, I performed a radical mastoidectomy on the left side. The mastoid cells appeared normal and were well pneumatized. A partial simple mastoidectomy was first performed. On opening the lateral wall of the epitympanum, an excellent view was obtained of a classical picture of a glomus jugulare tumor. Profuse bleeding occurred when the tumor was encountered. The mass completely filled the middle ear and the epitympanum and extended far anteriorly into the posterior extension of the zygoma. Erosion had been due to the pressure of the expanding tumor. No local invasion of the bone was present. It was noteworthy that most of the tympanic membrane was in place. The mass had herniated through the tympanic membrane anteriorly. Most of the tumor was attached to the hypotympanic area. On removal of the inferior portion of the tumor mass, bleeding was severe, but was readily controlled by packing. Palpation of the hypotympanic area failed to reveal an exposed jugulare bulb. Some of the tumor was left in the oval window around the stapes, and it was not possible to remove all of the tissue at the base. The patient received 1,500 cc. of blood during the procedure. Recovery was uneventful.

Postoperatively, she received roentgen therapy, consisting of a total dosage of 2,500 r. When she was last examined on Sept. 5, 1959, the cavity was well healed, and she was having no further difficulty.

Comment.—It is of interest that the jugular bulb was not exposed and the bone of the hypotympanum was intact in all three cases of this series in which operation was performed. Case 4 illustrates the importance of adhering to one's clinical impression in spite of a pathologic diagnosis to the contrary.

Case 5.—A 33 year old Negro woman, seen at the Duval Medical Center on June 2, 1959, complained of pain in the right ear of six weeks' duration and a mass in this ear noted two weeks after the onset of the pain. Slight discharge had occurred intermittently since that time. Two nights previously she had been examined in the outpatient clinic, and an unsuccessful attempt was made to aspirate the mass.

On examination, the external auditory canal of the right ear was completely occluded by a firm mass which was covered with epithelium (fig. 7). No discharge, mastoid tenderness, or facial weakness was evident. It was not possible to visualize the tympanic membrane. Roentgenograms of the mastoid gave negative results. No facilities were available for audiometric testing. The clinical diagnosis was glomus jugulare tumor.

A right radical mastoidectomy and decompression of the right facial nerve were performed on July 7. A tumor mass filled the entire external auditory canal and appeared to be lined with epithelium throughout. The pathologic diagnosis of a frozen section was tissue of neural origin, probably malignant. A partial simple mastoidectomy was first carried out. The mastoid cells appeared normal, and on removal of the outer wall of the epitympanum no neoplasm was noted. On elevation of the tumor mass from the external auditory canal, it was evident that it extend-

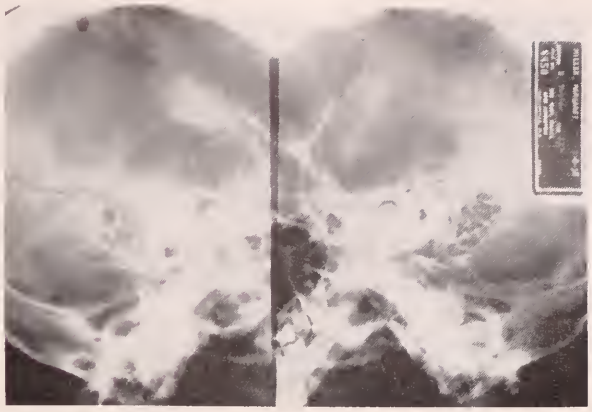


Fig. 5.—Case 3. Roentgenograms of the mastoids demonstrate marked sclerosis in the antral portion of the right mastoid in contrast to a normal left mastoid. The well preserved cells of the main portion of the right mastoid show only slight cloudiness, and there is no evidence of bone destruction.

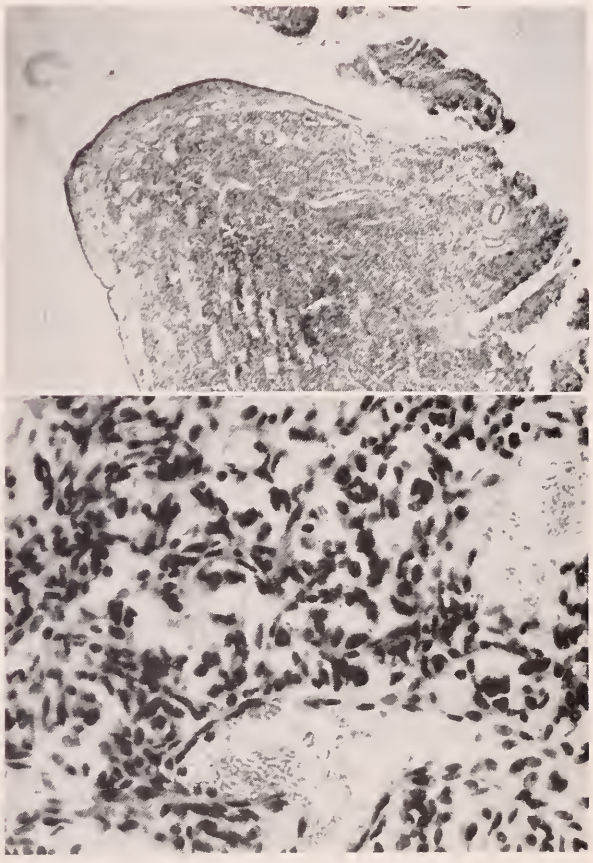


Fig. 6.—Case 3. Tissue from the middle ear of a 28 year old woman. a. (X38.4) Low power view showing cellular growth partially covered by a thin layer of squamous epithelium, with an immediately underlying fibrous layer. At this magnification it is seen that the tumor contains many blood vessels. b. (X 410) Higher magnification shows the sinusoidal vascular bed, about which are collars of elongated or polygonal-shaped cells. The latter have very pale cytoplasm and oval, moderately dark nuclei with chromatin particles. A few of these cells are "epithelioid" in appearance. Note the thin vascular wall.

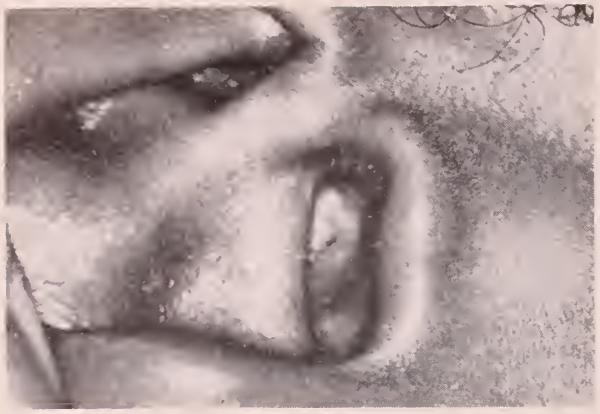


Fig. 7.—Case 5. A firm tumor mass, covered with epithelium, occludes the external auditory canal.



Fig. 8.—Case 5. The tumor appeared to arise from a glomus body in close proximity to the facial nerve, as shown in this illustration from Guild, S. R.[1] p. 1069, fig. 14.

ed posteriorly and inferiorly deep into the canal to a point where it appeared to break through. It was lying against the tympanic membrane.

At this point I thought I could perhaps save the middle ear. The neoplasm, however, appeared to extend along the chorda tympani nerve into the middle ear and it extended through the posterior wall of the external auditory canal to the facial nerve. This nerve was then decompressed from the horizontal semicircular canal down to the stylomastoid foramen. It was markedly edematous and thickened and had a deep purplish sheen. The tumor mass was attached to the neurilemma sheath and was now believed to be arising from it. The nerve was therefore completely elevated from its canal and all of the bone around it was removed. It appeared to be normal at the stylomastoid foramen. After neurolysis was carried out on the descending portion of the facial nerve, a radical mastoidectomy was performed. The middle ear was free of neoplasm. Despite the pathologic report of a malignant tumor of neural origin, it was deemed wise not to take more radical surgical measures until a frozen section was read. The final pathologic report established a diagnosis of glomus jugulare tumor.

Postoperatively, roentgen therapy was administered, the total dosage amounting to 3,000 r. Recovery was uneventful except for facial weakness, which had disappeared by October. At that time the cavity was completely healed.

COMMENT.—A radical mastoidectomy was performed in this case because of the suspected malignant disease. Otherwise, the middle ear could have been preserved. The tumor apparently arose from a glomus body in close proximity to the facial nerve (fig. 8).

Summary and Conclusions

The etiology, diagnosis, and management of glomus jugulare tumors are reviewed. Clinical experiences with three cases of microscopically diagnosed glomus jugulare tumor and two clinically suggestive cases are related.

Glomus jugulare tumors arise from glomus bodies located in the adventitia of the dome of the jugular bulb or along the course of the branches of the tympanic branch of the glossopharyngeal nerve and the auricular branch of the vagus nerve.

The differences in clinical symptoms and apparent site of origin of these tumors are due to the difference in location as shown by the variety of sites of the normal glomus bodies.

Surgery, surgery in conjunction with roentgen therapy, and roentgen therapy alone are the various modes of therapy.

References

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7. Weille, F. L., and Lane, C. S. Jr.: Surgical Problems Involved in Removal of Glomus-Jugulare Tumors, Laryngoscope 61:448-459 (May) 1951.
8. Williams, H. L.; Childs, D. S. Jr.; Parkhill, E. M., and Pugh, D. G.: Chemodectomas of Glomus Jugulare (Nonchromaffin Paragangliomas) With Especial Reference to Their Response to Roentgen Therapy, Tr. Am. Otol. Soc. 43:264-290 (Mar.) 1955.
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Marshall Taylor Doctors Building.



Program of Eighty-Seventh Annual Meeting

Hotel Americana, May 25-28, 1961
Bal Harbour, Miami Beach

Convention Headquarters

Headquarters is the Americana Hotel where all the activities are scheduled.

Registration

The Registration Desk is located in the Theatre Auditorium and will be open from 11:00 a.m. to 5:30 p.m. on Thursday and from 8:30 a.m. to 5:30 p.m. Friday and Saturday and from 8:30 a.m. to 4:00 p.m. Sunday. Each member is required to register and obtain an official identification badge before attending any sessions. Guests and ladies are also required to register. There is no registration fee. Printed programs are available at the desk.

Members are urged to present their permanent plastic membership cards from which both their registration card and badge will be stamped by machine.

President's Reception

The President's Reception will be held on the Starlite Patio from 6:30 to 7:30 p.m. Friday evening. Tickets will be $2.50 per person available at the Association's Registration Desk in the Theatre Auditorium and in the evening at entrance to Starlite Patio.

Technical Exhibits

The Technical Exhibits are located in the Theatre Auditorium and may be visited Thursday afternoon; Friday, Saturday and Sunday from 8:30 a.m. to 5:30 p.m. The exhibits are an important part of the annual convention and each physician will be well repaid by spending some time inspecting them.

Scientific Exhibits

Many Florida and out-of-state physicians have prepared scientific exhibits to show the results of their work. These exhibits are located in the Theatre Auditorium. A list is included in the official program.

Blue Shield

The annual meeting of Blue Shield is being held at approximately 4:00 p.m. on Thursday, following adjournment of the first meeting of the House of Delegates in the Grand Ballroom. There will be no conflicting meetings and all delegates seated at the first meeting of the House of Delegates are urged to attend. Delegates are active members of Blue Shield.

Golf

Information on the golf tournament will be included in the printed program. Competition will be for the Duval County Medical Society trophy won last year by Dr. James T. Shelden of Lakeland and the Orlando Loving Cup won by Dr. George M. Stubbs of Jacksonville.

Dr. Robert C. Piper is Chairman of the Committee on Golf, 3133 Ponce de Leon Blvd., Coral Gables.

Hobbies and Collections

The exhibition of hobbies and collections, begun at the 1960 Annual Meeting in Jacksonville, is being continued this year. The Committee on Scientific Work with the assistance of Dr. Wilfred Lansman of Miami Beach has arranged for the showing which is located in the Theatre Auditorium and its Foyer.

Scientific Films

A program of scientific films is being presented Thursday morning in the Grand Ballroom beginning at 11:00.

Anglers

Physicians desiring to arrange for fishing trips should contact Dr. John R. Hilsenbeck, 660 N. E. 95th St., Miami 38, Chairman, Committee on Fishing.

Order of Business

First Meeting
House of Delegates

Thursday, May 25, 1:30 p.m.
Grand Ballroom

1. Presentation of Personal Gavel to Speaker by Leo M. Wachtel
2. Call to Order by Speaker, Joseph S. Stewart
3. Invocation: Ralph B. Huston, D.D., Minister, First Methodist Church, South Miami
4. Announce membership of Credentials Committee:
   Hugh A. Carithers, Chairman
   Clarence L. Anderson
   Walter W. Sackett Jr.
5. Report of Credentials Committee: Hugh A. Carithers, Chairman
6. Motion to seat Delegates
7. Presentation and adoption of minutes of 1960 Annual Meeting published in The Journal of the Florida Medical Association, June, 1960
8. Remarks—Host Society: Willard L. Fitzgerald, President, Dade County Medical Association
9. Introduction of Individuals at Speakers' Table
   Vice-Speaker, Eugene G. Peek Jr.
   President, Leo M. Wachtel
   President-Elect, S. Carnes Harvard
   Secretary-Treasurer, Samuel M. Day
   Executive Director, Mr. W. Harold Parham
10. Remarks of the Speaker
11. Scientific Program: Thad Moseley, Chairman, Scientific Council
12. Remarks of E. Vincent Askey, President, American Medical Association
13. Recognition:
   Mrs. John M. Butcher, President, Woman's Auxiliary to the Florida Medical Association
   Mrs. W. Dean Steward, President-Elect, Woman's Auxiliary to the Florida Medical Assoication
   Fraternal Delegates: F. G. Eldridge, Valdosta and Harry B. O'Rear, Augusta
   Student American Medical Association Representatives:
   American Medical Association General Practitioner of the Year Award: James T. Cook Jr., Marianna
14. Presentation—Certificate of Merit
15. A. H. Robins Company Award—"For Outstanding Community Service by a Physician"
16. President's Annual Address: Leo M. Wachtel
17. Announcement of Reference Committee Personnel:
   I. HEALTH AND EDUCATION
      Henry L. Harrell, Chairman
      Thomas M. Irwin
      James L. Bradley
      Frank C. Bone
      Maurice M. Greenfield
   II. PUBLIC POLICY
      Francis N. Cooke, Chairman
      George W. Morse
      Frederick C. Andrews
      Charles R. Sias
      Clifford C. Snyder
   III. FINANCE AND ADMINISTRATION
      Richard F. Sinnott, Chairman
      Nelson H. Kraeft
      Linus W. Hewit
      Miles J. Bielek
      Ralph S. Sappenfield
   IV. LEGISLATION AND MISCELLANEOUS
      Eugene B. Maxwell, Chairman
      James T. Cook Jr.
      John P. Ferrell
      James F. Cooney
      Vincent P. Corso

   Meetings—Friday, May 26
   I. 9:00 a.m.—Westward Room
   II. 9:30 a.m.—Eastward Room
   III. 10:00 a.m.—Pan-American Room
   IV. 10:30 a.m.—Caribbean Room
18. Assignment of reports and resolutions
   (As published in the Handbook)
   I. HEALTH AND EDUCATION
      Council on Medical Education and Hospitals
      Scientific Council
      Council on Specialty Medicine
   II. PUBLIC POLICY
      Council on Allied Professions and Vocations
      Council on Voluntary Health Agencies
      Council on Medical Services
   III. FINANCE AND ADMINISTRATION
      Board of Governors
      Subcommittees of the Board
      Reports of Officers
      Judicial Council
   IV. LEGISLATION AND MISCELLANOUS
      Council on Legislation and Public Agencies
      Council on Medical Economics
      Council on Special Activities
19. Assignment of Supplemental Reports and Resolutions received too late for inclusion in the Handbook.
20. Additional Supplementary Reports and Resolutions
   Board of Governors
   Council on Allied Professions and Vocations
   Judicial Council
   Council on Legislation and Public Agencies
   Council on Medical Economics
   Council on Medical Education and Hospitals
   Council on Medical Services
   Scientific Council
   Council on Special Activities
   Council on Specialty Medicine
   Council on Voluntary Health Agencies
21. Other business
22. Announcements:
   Blue Shield Annual Meeting
      (Immediately following recess of House of Delegates)
   Exhibits
23. Recess until 1:30 p.m., Sunday, May 28, 1961

Scientific Film Program

Thursday, May 25

Grand Ballroom

11:00 a.m. "Man Returns to the Sea," G. Dekle Taylor, M.D., Jacksonville

Other Meetings

BLUE SHIELD OF FLORIDA

Russell B. Carson, President ..... Fort Lauderdale
John T. Stage, Secretary ..... Jacksonville

Thursday, May 25

Grand Ballroom
Immediately following adjournment of the first meeting of the House of Delegates.
Speaker: Mr. Pat N. Groner, Administrator, Baptist Hospital, Pensacola "Hospital Costs."

REFERENCE COMMITTEES

Friday, May 26

I. Health and Education—Westward Room—9:00 a.m.
II. Public Policy—Eastward Room—9:30 a.m.
III. Finance and Administration—Pan-American—10:00 a.m.
IV. Legislation and Miscellaneous—Caribbean Room—10:30 a.m.

FLORIDA MEDICAL COMMITTEE FOR BETTER GOVERNMENT

Saturday, May 27

Floridian Room
12:00 Noon Annual Meeting; Election of Officers
James T. Cook Jr., State Chairman, Marianna
O. E. Harrell, Secretary-Treasurer, Jacksonville

Social Functions

TULANE

Thursday, May 25

Carioca Terrace
6:00 p.m. Cocktails
8:00 p.m. Dinner

JEFFERSON

Thursday, May 25

Floridian Room
8:00 p.m. Dinner
Speaker: Kenneth E. Fry, M.D., Clinical Professor of Surgery, Jefferson Medical College, Philadelphia

PRESIDENT'S RECEPTION

Friday, May 26

Starlite Patio

6:30-7:30 p.m. No formal program. Tickets $2.50 per person, available at Association's Registration Desk during registration hours or entrance to Starlite Patio.

Scientific Assemblies

Friday, May 26

Grand Ballroom

FIRST SCIENTIFIC ASSEMBLY

Presiding: Franz H. Stewart, M.D.

9:00 a.m. **Diagnostic Clinic: Digestive Disease**
Introduction: Dr. Stewart
Moderator: Chester Cassel, M.D., Miami
Participants: George H. McSwain, M.D., Daytona Beach; F. P. Gargano, M.D., Miami; Winston K. Shorey, M.D., Miami, and James L. Borland, M.D., Jacksonville

10:00 a.m. **Diagnostic Clinic: Cardiovascular Disease**
Introduction: Dr. Stewart
Moderator: George T. Harrell, M.D., Gainesville
Participants: Francis N. Cooke, M.D., Miami; Oliver P. Winslow, M.D., Miami; Philip Samet, M.D., Miami; Karl B. Hanson, M.D., Jacksonville, and Charles K. Donegan, M.D., St. Petersburg

The protocol for the Diagnostic Clinic on Digestive Disease, prepared by Dr. Chester Cassel of Miami, may be found on pages 1248 and 1249 of this issue. The protocol for the Diagnostic Clinic on Cardiovascular Disease, prepared by Dr. George T. Harrell of Gainesville, is also in this issue beginning on page 1250.

SECOND SCIENTIFIC ASSEMBLY

Presiding: Charles K. Donegan, M.D.

2:00 p.m. **"Immediate Reconstruction of Severe Soft Tissue Injuries"**
D. Ralph Millard Jr., M.D., Miami

Discussion

2:20 p.m. **"Visceral Larva Migrans"**
Hilliard R. Reddick, M.D., Quincy

Discussion

2:40 p.m. **"A Review of Cholecystectomy"**
George M. Stubbs, M.D., Jacksonville

Discussion

3:00 p.m. Recess to visit exhibits

3:15 p.m. **"Blood Volume Determination and Its Surgical Significance"**
Harry W. Reinstine Jr., M.D., and Robert H. Anderson Jr., M.D., Jacksonville. Presented by Dr. Reinstine.

Discussion

3:35 p.m. **"Newer Methods for Detection of Congenital Cardiac Shunts"**
Philip Samet, M.D., and William H. Bernstein, M.D., Miami Beach, and H. Coleman Kramer, M.D., Hollywood. Presented by Dr. Bernstein.

Discussion

3:55 p.m. **"Clinical Use of a New Ventilatory Assistor"**
Asher Marks, M.D., Jose Bocles, M.D., and Loretta Morganti, M.D., Miami. Presented by Dr. Marks.

Discussion

General Session

Firday, May 26

Grand Ballroom

11:30 a.m. Call to Order
Presiding: Leo M. Wachtel, President

President's Guest Speaker
The Honorable George H. Smathers, United States Senator

Other Meetings

BOARD OF PAST PRESIDENTS

Friday, May 26

Gaucho Room

8:00 a.m. Breakfast
Election of a Chairman and Secretary
Shaler Richardson, Chairman and Ralph W. Jack, Secretary
(According to precedent, William C. Thomas Sr. will succeed the present chairman and Leo M. Wachtel the present secretary.)

Scientific Assemblies

Saturday, May 27

Grand Ballroom

THIRD SCIENTIFIC ASSEMBLY

Presiding: Richard F. Sinnott, M.D.

9:00 a.m. **"Present Role of Cancer Chemotherapy by Perfusion"**
Oscar Creech Jr., M.D., New Orleans, William Henderson Professor of Surgery and Chairman of the Department of Surgery, Tulane University School of Medicine.

9:20 a.m. **"Diagnostic Radioisotopes"**
Charles A. Owen Jr., M.D., Rochester, Minn., Head, Section of Biochemical Research, Mayo Clinic, and Professor of Medicine (Medical Research), Mayo Foundation, University of Minnesota Medical School.

9:30 a.m. **"Chemotherapy in Juvenile Cancers"**
Harold W. Dargeon, M.D., New York, Chairman of the Department of Pediatrics, Memorial Hospital for Cancer and Allied Diseases, and Associate Professor of Clinical Pediatrics, Cornell University Medical College.

10:00 a.m. Recess to visit exhibits

10:10-11:10 **Panel: "What Do You See in the Future for the Treatment of Cancer?"**
Moderator: Ralph Jones Jr., M.D., Miami
Participants: Drs. Creech, Owen and Dargeon

11:10 a.m. Recess to visit exhibits

11:20 a.m. **"Unilateral Renal Disease and Its Role in Hypertension"**
Robert S. Hotchkiss, M.D., New York, Professor and Chairman of the Department of Urology, New York University College of Medicine, and Visiting Surgeon in Charge, Fourth Surgery Division (Urology), Bellevue Hospital.

11:40 a.m. **"Anesthesiology and the Hypertensive Patient"**
John Adriani, M.D., New Orleans, Professor of Surgery (Anesthesiology), Tulane University School of Medicine; Clinical Professor of Surgery and Pharmacology, Louisiana State University School of Medicine, and Director, Department of Anesthesiology, Charity Hospital of Louisiana.

Meeting of Specialty Societies

Florida Allergy Society

I. Irving Weintraub, President.....Gainesville
Solomon D. Klotz, Pres.-Elect.....Orlando
Benjamin A. Johnson Jr., Secy.-Treas.....Jacksonville

Saturday, May 27

Rooms 204-205

2:00 p.m. Business Meeting

Sunday, May 28

Rooms 204-205

10:00 a.m. Scientific Session
"Heparin: Theoretical, Physio-Pharmacological and Practical Observations in Relation to Its Use in the Allergic Individual," Albert M. Ziffer and Solomon D. Klotz, Orlando

"The 'Inhalants' of Florida," A symposium based on investigational and clinical experiences in the allergic practice of different Florida regions, Melvin Newman, Jacksonville; Nelson Zivitz, Miami Beach, G. Frederick Heiber, St. Petersburg, and I. Irving Weintraub, Gainesville

Florida Society of Anesthesiologists

Richard S. Hodes, President.....Tampa
James D. Beeson, Pres.-Elect.....Jacksonville
George H. Mix, Vice Pres.....Lakeland
J. Thomas Atkins, Secy.-Treas.....Jacksonville

Saturday, May 27

Gaucho Room

2:00 p.m. Board of Directors Meeting

4:00 p.m. **"Antiemetics and Other Adjunctive Drugs"**
John Adriani, New Orleans, Professor of Surgery, Tulane University School of Medicine; Clinical Professor of Surgery and Pharmacology, Louisiana State University School of Medicine, and Director, Department of Anesthesiology, Charity Hospital of Louisiana at New Orleans

Sunday, May 28

Bal Masque Room

9:00 a.m. Guest of Florida Chapter, American College

of Surgeons. "Cardiac Arrest," Oscar Creech Jr., New Orleans
Discussion: Dr. Adriani

Yucatan-Aztec Room

10:15 a.m. Annual Business Meeting

Florida Chapter, American College of Chest Physicians

Ivan C. Schmidt, President ..... West Palm Beach
Charles F. Tate Jr., Vice Pres. ..... Miami
Harold W. Johnston, Secy.-Treas. ..... Orlando
Dwight J. Wharton, Program Chairman ..... Jacksonville

Saturday, May 27

Embassy Room, Balmoral Hotel

12:30 p.m. Luncheon and Business Meeting

2:00 p.m. Remarks, M. Jay Flipse, Miami, President, American College of Chest Physicians

2:20 p.m. "Abnormal Mechanics of Breathing," Asher Marks, Miami, Department of Medicine, University of Miami School of Medicine

2:40 p.m.—"Physiological Approach to Respiratory Failure," David M. Travis, Gainesville, Department of Medicine, University of Florida College of Medicine

3:00 p.m. "Surgical Aspects of Emphysema," Richard G. Connar, Tampa

3:20 p.m. "The Medical Evaluation and Management of Pulmonary Emphysema," Herbert O. Sieker, Durham, N. C., Department of Medicine, Duke University School of Medicine

3:40 p.m. Discussion

5:00 p.m. Adjournment

Florida Society of Dermatology

Jack H. Bowen, President ..... Jacksonville
Meyer Yanowitz, Vice Pres. ..... Miami
William C. Croom Jr., Secy-Treas. ..... Jacksonville

Program and place of meeting to be announced.

Florida Academy of General Practice

Willard E. Manry Jr., President ..... Lake Wales
James T. Cook Jr., Pres.-Elect ..... Marianna
A. MacKenzie Manson, Secy.-Treas. ..... Jacksonville
Walter J. Glenn Jr., Program Chairman ..... Fort Lauderdale

Saturday, May 27

Pan-American Room

2:00 p.m. Board of Directors Meeting

Sunday, May 28

Pan-American Room

9:00 a.m. Scientific Session
"The Patient with a Blood Clotting Problem," Charles A. Owen Jr., Rochester, Minn., Head, Section of Biochemical Research, Mayo Clinic, and Professor of Medicine (Medical Research) Mayo Foundation, University of Minnesota Medical School

10:00 a.m. General Business Session

Florida Health Officers' Society

J. Basil Hall, President ..... Tavares
Edward R. Smith, Vice Pres. ..... Jacksonville
James O. Bond, Secy.-Treas. ..... Jacksonville

Sunday, May 28

Heather Room, Balmoral Hotel

10:00 a.m. "Community Organization to Meet the Problem of the Mentally Retarded Child," Richard G. Skinner Jr., M.D.

10:20 a.m. Report on a Community Cancer Demonstration Project—Dade County, James E. Fulghum, M.D., and Robert J. Klein, M.D.

10:40 a.m. A Survey for Amebiasis in Jackson County, Florida, Terry Bird, M.D.

11:00 a.m. "A School Tuberculin Testing Program Conducted Through Lay Volunteers, Vera Kares, and Paul W. Hughes, M.D.

11:20 a.m. "Mobilizing Community Resources to Aid Those Returning from Mental Hospitals," John S. Neill, M.D.; R. E. Cummings, M.D.; M. E. Nassau, M.S.W., and T. Northcut, Ph.D.

11:40 a.m. Business Session

Florida Association of Industrial and Railway Surgeons

Fred H. Albee Jr., President ..... Daytona Beach
Henry J. Babers Jr., Pres.-Elect ..... Gainesville
Samuel S. Lombardo, Vice Pres. ..... Jacksonville
John H. Mitchell, Secy.-Treas. ..... Jacksonville

Saturday, May 27

Grand Ballroom

1:00 p.m. Panel Discussion
"The Industrial Case in the Eyes of the Following —A Doctor, A Lawyer, Adjuster and Industrial Commissioner"

2:15 p.m. "Good and Bad Reconstructive Surgical Procedures in Paralytic Patients," Paul L. Reith, Chief Surgeon, Warm Springs Foundation, Warm Springs, Ga.
Discussion: Robert P. Keiser, Coral Gables
James J. Conners, Jacksonville

3:15 p.m. "Indications for Osteotomy in the Adult Hip Joint," Speaker to be announced.
Discussion: Royston Miller, Orlando
Irwin S. Leinbach, St. Petersburg

4:15 p.m. Business Meeting

Scientific Session is being held in conjunction with Florida Orthopedic Society.

Florida Society of Internal Medicine

William C. Blake, President ..... Tampa
Scheffel H. Wright, Pres.-Elect ..... Miami
Norval M. Marr Sr., Vice Pres. ..... St. Petersburg
Charles K. Donegan, Secy.-Treas. ..... St. Petersburg

Sunday, May 28

Gaucho Room

9:00 a.m. Business meeting

(Program continues next page)

11:00 a.m. "The Scroll on the Wall," Mr. Horace Cotton, Executive Editor, Medical Economics

12:00 a.m. Social Hour

Florida Neurosurgical Society

Irwin Perlmutter, President.....Coral Gables
Christian Keedy, Pres.-Elect.....Miami
David H. Reynolds, Secy.-Treas.....Miami

Sunday, May 28

Room 207

9:00 a.m. "Anterior Cervical Spine Fusion," George W. Smith, Associate Professor of Neurosurgery, Department of Neurological Surgery, Medical College of Georgia, Augusta

Business Meeting (time to be announced)

Florida Obstetric and Gynecologic Society

T. Bert Fletcher Jr., President.....Tallahassee
James R. Sory, Pres.-Elect.....West Palm Beach
Sam W. Denham, Secy.-Treas.....Jacksonville

Saturday, May 27

Starlite Patio

6:30 p.m. Cocktail Party

Sunday, May 28

Eastward Room

10:00 a.m. Business Session

Scientific Session

"The Use of Intranasal Pitocin for the Induction and/or Stimulation of Labor," John R. McCain, Assistant Professor, Department of Obstetrics and Gynecology, Emory University School of Medicine, Atlanta

Florida Society of Ophthalmology and Otolaryngology

Kenneth S. Whitmer, President .....Miami
William H. Anderson Jr., Pres.-Elect .....Ocala
Marion W. Hester, 1st Vice Pres. .....Lakeland
J. Brown Farrior, 2nd Vice Pres. .....Tampa
Joseph W. Taylor Jr., Secy.-Treas. .....Tampa

Saturday, May 27

Caribbean Suite

2:00 p.m. Business Session

6:30 p.m. Cocktail Party

Sunday, May 28

Caribbean Suite

Scientific Session Ophthalmology

10:00 a.m. "Unbreakable Lens Material for Spectacles," Thomas G. Dickinson, Sarasota
Discussion

10:20 a.m. "Fever Therapy in Ophthalmology," Spencer R. Garrett, Lakeland
Discussion: William M. Kummer, Lakeland

10:40 a.m. "Fusarium Keratomycosis Treated Successfully with Systemic Grifulvin," James A. Stokes, Orlando.
Discussion: Thomas S. Edwards, Jacksonville

11:00 a.m. "Retinoblastoma—Review of Cases," Charles F. McCrory, Jacksonville
Discussion: Joseph W. Taylor Jr., Tampa

11:20 a.m. "Candida Albicans Infection of the Eye with Corneal Perforations Successfully Treated After Control of the Infection with Lamellar Graft," Sherman B. Forbes, Tampa
Discussion: Edward W. D. Norton, Miami

11:40 a.m. "New Eye Dressing Tray," Younger A. Staton, West Palm Beach

12:00 a.m. Symposium on Contact Lenses
Moderator: Frederick E. Hasty, Coral Gables
Panelists: Harry Horwich, Coral Gables, and Robert C. Welsh, Miami

12:30 p.m. Dutch Buffet

Scientific Session Otolaryngology

8:00 a.m. Breakfast Buffet

8:50 a.m. Announcements

9:00 a.m. "A Radiographic-Anatomic Study of the Paranasal Sinuses," Darby Glenn, Resident, Jackson Memorial Hospital, Miami

9:10 a.m. "Osteomyelitis of the Superior Maxilla," Stanley Cannon, Resident, Jackson Memorial Hospital, Miami

9:20 a.m. "Nasal Surgery in the Allergic Patient," Frederick D. Droege, Sarasota

9:30 a.m. "Individualization of Nasal Corrective Surgery," Richard T. Farrior, Tampa

9:40 a.m. "The Prevention of Hemorrhage Following Tonsillectomy and Adenoidectomy," Curtis D. Benton Jr. and James W. McCann Jr., Fort Lauderdale

9:50 a.m. "Hypnosis in Otolaryngology," Albert J. Davis Jr., St. Petersburg

10:00 a.m. Discussion and Intermission

10:30 a.m. "Percentage Hearing Loss, A Valid Concept," Harris I. Pomerantz, M.S., University of South Florida, Tampa

10:40 a.m. "Experiences with Primary Closure of the Radical Mastoid Cavity," Wallace Hahn, Resident, Jackson Memorial Hospital, Miami

10:50 a.m. "Otosclerosis Surgery, Its Occupational Status," Bernard M. Barrett, Pensacola

11:00 a.m. "Experiences with Vein Graft Myringoplasty," William F. Shipman Jr., Tallahassee

11:10 a.m. "Congenital Atresia of Auditory Canal with Spontaneous Canalization," George H. Schoetker, Clearwater

11:15 a.m. Discussion—Otology

11:30 a.m. "Our Cancer Problem," J. Ryan Chandler Jr., Miami

11:40 a.m. "Upper Laryngectomy and Neck Resection, Case Report," Claude Burpee, Resident, Otolaryngology, Tampa General Hospital, Tampa

11:45 a.m. "Maxillary Tumors," Worth I. Dunn, Resident, Otolaryngology, Tampa General Hospital, Tampa

12:00 a.m. "Complications of Nitrogen Mustard Therapy of Head and Neck Cancer," Stephen L. Kyler, West Palm Beach

12:10 p.m. Discussion—Cancer of the Head and Neck

12:30 p.m. Dutch Buffet

Florida Orthopedic Society

Michael A. DiCosola, President ... Sarasota
Wendell J. Newcomb, Pres.-Elect ... Pensacola
Richard A. Worsham, Vice Pres. ... Jacksonville
Theodore Norley, Secy.-Treas. ... West Palm Beach
Irwin S. Leinbach, Program Co-Chairman St. Petersburg
James L. West Jr., Program Co-Chairman St. Petersburg

Saturday, May 27

Grand Ballroom

1:00 p.m. Panel Discussion
"The Industrial Case in the Eyes of the Following —A Doctor, A Lawyer, Adjuster and Industrial Commissioner"

2:15 p.m. 'Good and Bad Reconstructive Surgical Procedures in Paralytic Patients," Paul L. Reith, Chief Surgeon, Warm Springs Foundation, Warm Springs, Ga.
Discussion: Robert P. Keiser, Coral Gables
James J. Conners, Jacksonville

3:15 p.m. "Indications for Osteotomy in the Adult Hip Joint," Royston Miller, Orlando and Irwin S. Leinbach, St. Petersburg

6:30 p.m. Cocktail Party—Patio Terrace

Sunday, May 28

Grand Ballroom

9:00 a.m. Business Meeting

Scientific Session is being held in conjunction with Florida Association of Industrial and Railway Surgeons.

Florida Pediatric Society

J. K. David Jr., President ... Jacksonville
Fred I. Dorman Jr., Pres.-Elect ... Lakeland
John H. Cordes Jr., Secretary ... St. Petersburg
Robert J. Grayson, Treasurer ... Miami Beach

Saturday, May 27

Medallion Room

2:00 p.m. "Leukemia and Lymphoma," Harold W. Dargeon, Chairman, Department of Pediatrics, Memorial Hospital for Cancer and Allied Diseases, and Associate Professor of Clinical Pediatrics, Cornell University Medical College, New York City

3:00 p.m. Coffee Break

3:15 p.m. Panel Discussion
Harold W. Dargeon, New York
Demetrius G. Traggis, Miami
James A. Whiteside, Coral Gables
William A. Shaver, Miami
Michael M. Gilbert, Miami

4:15 p.m. Executive Committee Meeting

6:30 p.m. Cocktail Party and Dinner

Sunday, May 28

Medallion Room

9:00 a.m. "Neuroblastoma," Dr. Dargeon

10:00 a.m. Coffee Break

10:15 a.m. Panel Discussion
Drs. Traggis, Whiteside, Shaver and Gilbert

11:15 a.m. Business Meeting

Florida Society of Pathologists

John B. Miale, President ... Miami
Robert J. Davis, Vice Pres. ... Tampa
W. Ansell Derrick, Treasurer ... Orlando
John A. Shively, Secretary ... Bradenton
Millard B. White, Program Chairman ... Sarasota

Saturday, May 27

Rooms 202-203

2:00 p.m. Program to be announced

Sunday, May 28

Rooms 202-203

9:00 a.m. Business meeting

Florida Society of Plastic and Reconstructive Surgery

Joseph E. O'Malley, President ... Orlando
Bernard L. N. Morgan, Vice Pres. ... Jacksonville
John M. Hamilton, Secy-Treas. ... St. Petersburg

Saturday, May 27

Room 201

2:00 p.m. Business Meeting
Scientific presentation, W. John Pangman, Beverly Hills, Calif.

Sunday, May 28

Room 201

9:30 a.m. Breakfast. E. L. Matta Jr., Director, Florida Crippled Children's Commission, Speaker

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Florida Proctologic Society

Matthew A. Larkin, President ... Miami
Frederick E. Farrer, Secy.-Treas. ... Miami

Saturday, May 27

Room 206

2:00 p.m. Program to be announced

Sunday, May 28

Room 206

9:00 a.m. Program to be announced

Florida Psychiatric Society

Samuel G. Hibbs, President ... Tampa
Rodman Shippen, Pres.-Elect ... Orlando
Merton L. Ekwall, Secretary ... Jacksonville
Walter H. Wellborn Jr., Treasurer ... Tarpon Springs
Albert C. Jaslow, Program Chairman ... Miami

Saturday, May 27

Floridian Room

1:00 p.m. Meeting of Council

2:00 p.m. Business Session

6:30 p.m. Cocktail Party and Dinner

(Program continues next page)

Sunday, May 28

Floridian Room

9:30 a.m. "Suicide—Observations from a Clinical and Research Standpoint," H. L. P. Resnik, Resident, University of Miami School of Medicine, Miami
Discussion

10:00 a.m. "Prejudice, Hostility and Dependency," Zack Russ Jr., Tampa
Discussion

10:30 a.m. Coffee Break

11:00 a.m. "Psychiatry in the Community," Mathew Ross, Medical Director, American Psychiatric Association, Washington, D. C.

Florida Radiological Society

John S. Stewart, President ..... Fort Myers
John P. Ferrell, Pres.-Elect ..... St. Petersburg
Ivan Isaacs, Vice Pres. ..... Jacksonville
Alfred G. Levin, Secretary ..... Miami
Richard D. Shapiro, Treasurer ..... Miami Beach

Saturday, May 27

Westward Room

1:00 p.m. Scientific Session
Members of the Society are requested to bring their interesting films for presentation. Members of the Florida Medical Association also are invited to bring films for discussion and diagnosis.

6:30 p.m. Cocktail Party and Dinner

Sunday, May 28

Westward Room

9:00 a.m. Business Session

Florida Urological Society

H. Lawrence Smith Jr., President ..... Tallahassee
William A. VanNortwick, Pres.-Elect ..... Jacksonville
Henry C. Hardin Jr., Secy.-Treas. ..... Miami

Saturday, May 27

Yucatan-Aztec Room

2:00 p.m. Business Session

3:00 p.m. Scientific Session
"Male Genital Tract Physiology: The Role of Enzymes in Epididymal and Prostatic Function," Robert S. Hotchkiss, New York City, Professor and Chairman, Department of Urology, New York University School of Medicine
Round Table Discussion: "Treatment of Male Infertility, 1961," Dr. Hotchkiss, moderator

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Florida Chapter, American College of Surgeons

Donald W. Smith, President ..... Miami
C. Frank Chunn, Pres.-Elect ..... Tampa
Willard F. Ande, Vice Pres. ..... West Palm Beach
Charles Larsen Jr., Secy.-Treas. ..... Lakeland

Saturday, May 27

Bal Masque Room

6:00 p.m. Cocktails for members and wives

Sunday, May 28

Bal Masque Room

9:00 a.m. Scientific Program

"Cardiac Arrest—Its Prevention and Management," Oscar Creech Jr., New Orleans, Professor of Surgery, Tulane University School of Medicine
Discussion: John Adriani, New Orleans, Director, Department of Anesthesia, Charity Hospital of Louisiana
"Surgical Injuries to the Lower Urinary Tract," Frank M. Woods, Miami

Business Meeting

Florida Association of General Surgeons

Richard M. Fleming, President ..... Miami
Jack A. MaCris, Pres.-Elect ..... St. Petersburg
Emmet F. Ferguson Jr., Secy.-Treas. ..... Jacksonville

Saturday, May 27

Eastward Room

2:00 p.m. Program to be announced

Order of Business

Second Meeting
House of Delegates

Sunday, May 28, 1:30 p.m.

Grand Ballroom

1. Call to Order by Speaker, Joseph S. Stewart
2. Report of Credentials Committee: Hugh A. Carithers, Chairman
3. Reports of Reference Committees:
   I. HEALTH AND EDUCATION
   Henry L. Harrell, Chairman
   II. PUBLIC POLICY
   Francis N. Cooke, Chairman
   III. FINANCE AND ADMINISTRATION
   Richard F. Sinnott, Chairman
   IV. LEGISLATION AND MISCELLANEOUS
   Eugene B. Maxwell, Chairman
4. Other unfinished business
5. Election of Association's Officers:
   President-Elect
   Vice President

Speaker of the House
Vice Speaker of the House
Secretary
Treasurer

6. Delegates to American Medical Association
   Two delegates and two alternates to the House of Delegates, American Medical Association, for two year terms beginning Jan. 1, 1962
   Terms expiring Dec. 31, 1961:
   Delegate—Meredith Mallory
   Alternate—Eugene G. Peek Jr.
   Delegate—Burns A. Dobbins Jr.
   Alternate—Walter E. Murphree

7. Committee on Membership and Discipline
   (Nominations by Board of Governors; additional nominations from the floor)

8. Nomination for General Practitioner of the Year
   (Nominations by Board of Governors)

9. Escort Dr. Harvard to the Rostrum

10. Presentation of Personal Gavel to Dr. Harvard by Dr. Wachtel

11. Presentation of Past President's button and Certificate to Dr. Wachtel by Dr. Harvard

12. Presentation of Dr. Wachtel's picture to Mrs. Wachtel by Dr. Harvard

13. Announcement of Post-Convention Board meeting and new Board members by Dr. Harvard

14. Benediction: Homer L. Pearson Jr.

15. Adjournment

Technical Exhibits

Technical exhibits are located in the Exhibit Hall of the Americana Hotel. They have real scientific value, and physicians who wish to keep abreast of the times and be familiar with the latest developments in drugs and medical appliances should spend some time with these exhibits; a surprising amount of useful information can be procured in this way.

Many exhibitors make no attempt to sell, the representatives of the firms being there primarily to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting. The following firms have arranged for exhibits at the Bal Harbour meeting:

Exhibitors	Booth
Abbott Laboratories	96
American Sterilizer Co.	11
Anderson Surgical Supply Co.	43
Audio-Digest Foundation	106
Borcherdt Co.	72
The Borden Co.	65
George A. Breon & Co.	44
Charles Bruning Co., Inc.	13
Burroughs Wellcome & Co.	85
Carnation Co.	86
G. W. Carnrick Co.	9
Chicago Pharmacal Co.	66
Chloraseptic Co.	3
Ciba Pharmaceutical Products, Inc.	31
Coca-Cola Co.	7
Coreco Research Corp.	83
Commonwealth Fund	57
Delta Drug Corp.	19
Desitin Chemical Co.	14
Dictaphone Corp.	8
Doho Chemical Corp.	60
Dome Chemicals, Inc.	49
Drug Specialties, Inc.	6
Eaton Laboratories	102
Encyclopaedia Britannica, Inc.	82
Enfield's	103
H. G. Fischer & Co.	55
Flint, Eaton & Co.	109
Florida Brace Corp.	2
Geigy Pharmaceuticals	42
Great Books of the Western World	5
Guild of Prescription Opticians of Fla.	32
Hoffmann-LaRoche, Inc.	4
Johnson & Johnson	17
Keisacker	91
Keleket X-Ray of Fla.	51
LaHuis Clinical Laboratories	38
Lanier Gray Audograph	93
Eli Lilly & Co.	64
Lloyd Brothers, Inc.	16
Loma Linda Food Co.	54
Maico Hearing Service	27
J. A. Majors Co.	95
Maltbie Laboratories	30
Manhattan Uniform Co.	92
S. E. Massengill Co.	70
Mead Johnson & Co.	71
Medco Products, Inc.	56
Medical Protective Co.	100
Medical Supply Co. of Miami	101
Medical Supply Co. of Jacksonville	79
Merck Sharp & Dohme, Inc.	50
Wm. S. Merrell Co.	21
C. V. Mosby Co.	36
V. Mueller & Co.	78
Mutual Benefit Life Ins. Co.	24
National Drug Co.	112
Organon, Inc.	52
Ortho Pharmaceutical Corp.	28
Parke-Davis & Co.	67
Personal Products Corp.	22-23
Pet Milk Co.	37
Pfizer Laboratories	104
Wm. P. Poythress & Co., Inc.	73
Records-Med., Inc.	105
R. J. Reynolds Tobacco Co.	115
Riker Laboratories	63
A. H. Robins Co., Inc.	20
J. B. Roerig & Co.	18
Sanborn Co.	12
Sandoz Pharmaceuticals	29
Schering Corp.	15
Julius Schmid, Inc.	111
G. D. Searle & Co.	84
Sherman Laboratories	113
E. R. Squibb & Sons	80
The Stuart Co.	108
Surgical Equipment	45-46
Surgical Supply Co.	59
S. J. Tutag & Co.	110
The Upjohn Co.	47
VanPelt & Brown, Inc.	58
Walker Laboratories	114
Westwood Pharmaceuticals	107
White Laboratories, Inc.	48
Winthrop Laboratories	90
Zeigler of Florida, Inc.	10

Scientific Exhibits

Exhibit Hall

1 Telephone Service, Dade County Medical Association

S1-2 "A Medical Adventure in International Goodwill," Theodore Norley, M.D., West Palm Beach; Charles Hauser, M.D., and Allan McKelvie, M.D.

S3-4 "The Papanicolaou Smear as a Screening Test for Cancer," Wesley L. Southerland, M.D., Medical College of Georgia, Augusta

S5 "Nasal Deformities: Anatomical Consideration in Correction," Thomas J. Zaydon, M.D., Miami

S6 "The Character of the Physician," Medical Library and Department of History of Medicine, University of Miami School of Medicine

S7 "Cervical Cytology — A Gynecologic Challenge," J. Allan Offen, M.D., Miami

S8 "Acceptable Operations on the Biliary Tract," Harry W. Reinstine Jr., M.D., and Emmet F. Ferguson Jr., M.D., Jacksonville

S9 "Experimental and Clinical Use of Fibrinolysin," Paul W. Boyles, M.D., William H. Meyer, M.D., and Paul U. Gerber Jr., M.D., Coagulation Research Department, Miami Heart Institute, and University of Miami School of Medicine, Miami

S10 "Delayed Postoperative Anorectal Hemorrhage: Newer Developments and Techniques in Its Control," Frederick E. Farrer, M.D., Miami

S11-12 "Pathogenesis of Synovial Osteochondromatosis," William F. Enneking, M.D., University of Florida College of Medicine, Gainesville

S13 "Significance of Vocal Cord Paralysis; Its Symptoms and Diagnosis," James R. Chandler Jr., M.D., Miami

S14 "C. D. E. H. Hospital Model," Office of Civil and Defense Mobilization, Thomasville, Ga.

S16 "Face Pealing: A Chemical Method of Eradicating Facial Blemishes and Wrinkles," Thomas J. Baker, M.D., Miami

S17-18 Newton C. McCollough, M.D., Orlando

S19 "Problems of the Premature Infant," Lorenzo L. Parks, M.D., Bureau of Maternal and Child Health, Florida State Board of Health, Jacksonville

S20 Arthritis and Rheumatism Foundation, Miami

S21 "Institutional Management of Mentally Retarded," Charles H. Carter, M.D., Sunland Training Center, Orlando

S22 "The Physician and the Teen Age Smoking Problem," Florida Division, American Cancer Society

S23 "Help and Hope for the Dystrophic Patient," Muscular Dystrophy Associations of America, Inc., New York City

S24-26 Florida State Board of Health, Jacksonville

S27 College of Pharmacy, University of Florida, Gainesville

S28 Woman's Auxiliary to the Florida Medical Association, Mrs. John M. Butcher, President, Sarasota

S29-30 "Lymphography," Raymond E. Parks, M.D., and Manuel Viamonte, M.D., Jackson Memorial Hospital and University of Miami School of Medicine, Miami

33 Blue Shield of Florida, Inc., Russell B. Carson, M.D., President, Fort Lauderdale

34 "Automotive Crash Injury Research," Mr. Robert A. Wolf, Director, Automotive Crash Injury Research of Cornell University, New York City

35 "Sunlight and the Skin," American Medical Association, Chicago

40 "Reconstruction After Head and Neck Surgery," John J. Fomon, M.D., University of Miami School of Medicine; Head and Neck Service and Tumor Clinic, Jackson Memorial Hospital, Miami

41 "Regional Perfusion in Man," Daniel S. Martin, M.D., Associate Professor of Surgery, and Director, Surgical Research Laboratories, University of Miami School of Medicine, Miami

61 "A Comparative Review of the Methods of Practicing Medicine — 'Then and Now,' " Committee on Archives, Florida Medical Association, Clifford C. Snyder, M.D., Miami, Chairman

74-75 "The Holistic Treatment of Reactive Depressions," Michael M. Gilbert, M.D., Miami

76 "Nutrition Nonsense," American Medical Association, Chicago

77 Health Insurance Council

89 "Microwave Studies," Wm. B. Deichmann, Ph.D., University of Miami School of Medicine, Coral Gables

98 Florida Medical Association Investment Trust

99 Florida Medical Association Insurance Program

PROGRAM
THIRTY-FOURTH ANNUAL MEETING
WOMAN'S AUXILIARY
TO THE FLORIDA MEDICAL ASSOCIATION

HOSTESS AUXILIARY: Woman's Auxiliary to the Dade County Medical Association

Convention Chairman — Mrs. William P. Smith
Co-Chairman — Mrs. Wesley S. Nock

CONVENTION COMMITTEE CHAIRMEN

Credentials and Registration	Mrs. Frederick B. Zaugg
Treasurer	Mrs. Francis N. Cooke
Publicity	Mrs. John W. Dix
Decorations	Mrs. Harold M. Unger
Exhibits	Mrs. Arthur W. Wood Jr.
Luncheon	Mrs. Reuben B. Chrisman Jr.
Reservations	Mrs. Robert L. Tindall
Golf	Mrs. Manuel A. Schofman
Hospitality	Mrs. Donald F. Marion
Medical Association Exhibit	Mrs. Russell B. Carson

AD HOC COMMITTEE CHAIRMEN

Courtesy Resolutions	Mrs. Willard R. Gatling
Election	Mrs. Charles H. Gilliland
Reading	Mrs. Breckinridge W. Wing
Timekeeper	Mrs. C. Brooks Henderson
Observer Corps	Mrs. Edward W. Ludwig

GENERAL INFORMATION

GENERAL REGISTRATION will be held along with registration of Members of the Florida Medical Association at the Americana Hotel, Thursday, 11 a.m. to 5:30 p.m., Friday and Saturday, 8:30 a.m. to 5:30 p.m., and Sunday, 8:30 a.m. to 4:00 p.m.

REGISTRATION FOR DELEGATES to Auxiliary House of Delegates, Friday, 2:30 to 4:30 and Saturday, 9:00 to 10:00 a.m. in BAL MASQUE ROOM, AMERICANA HOTEL.

AUXILIARY MEETINGS, Hospitality room, Exhibits, Luncheons, will be in BAL MASQUE ROOM.

DAILY SCHEDULE

THURSDAY, May 25

1:30 p.m. First Meeting, House of Delegates Florida Medical Association
Auxiliary Members invited to hear Presidents' Address by Dr. Leo M. Wachtel

FRIDAY, May 26
Bal Masque Room

10:00 a.m. Pre-Convention Board of Directors Meeting Mrs. John M. Butcher, Presiding

1:00 p.m. Buffet Luncheon, Husbands welcome Highlights of County Auxiliary Activities

2:30 to 4:30 p.m. Pre-registration, Auxiliary House of Delegates Meeting

2:30 p.m. Membership Committee Meeting
Mrs. W. Dean Steward, Presiding
(Meeting will be held in suite of Auxiliary President and President-Elect)

3:30 to 4:30 p.m. Interview Hour — President and President-Elect

6:30 p.m. Florida Medical Association President's Reception

SATURDAY, May 27
Bal Masque Room

9:00 to 10:00 a.m. REGISTRATION FOR AUXILIARY HOUSE OF DELEGATES MEETING

11:00 a.m. ANNUAL MEETING OF HOUSE OF DELEGATES WOMAN'S AUXILIARY to the FLORIDA MEDICAL ASSOCIATION. All Auxiliary Members are invited to attend.

12:30 BUFFET LUNCHEON, Husbands welcome

2:00 p.m. Post-Convention Board Meeting and School of Instruction
Mrs. W. Dean Steward, Presiding

5:30 p.m.—Auxiliary Exhibits and Hospitality Room closed.

PROGRAM FOR ANNUAL MEETING HOUSE OF DELEGATES

Saturday, May 27, 1961—10:00 a.m.
Bal Masque Room — Hotel Americana

CALL TO ORDER: Mrs. John M. Butcher, President

INVOCATION: Mrs. S. Carnes Harvard

PLEDGE OF LOYALTY: *I pledge my loyalty and devotion to the Woman's Auxiliary to the Florida Medical Association. I will support its activities, protect its reputation, and ever sustain its high ideals.* Led by Mrs. Russell B. Carson

ADDRESS OF WELCOME: Mrs. William G. Aten Jr., President, Woman's Auxiliary to the Dade County Medical Association

RESPONSE TO THE WELCOME ADDRESS: Mrs. Philip L. Smoak

INTRODUCTIONS: Mrs. John M. Butcher

REMARKS FROM PRESIDENT, FLORIDA MEDICAL ASSOCIATION: Dr. Leo M. Wachtel

REMARKS FROM THE CHAIRMAN OF THE ADVISORY BOARD: Dr. Gordon H. Ira

PRESENTATION OF CONVENTION CHAIRMEN AND ANNOUNCEMENTS: Mrs. William P. Smith, Convention Chairman

CONVENTION RULES OF ORDER: Mrs. Millard B. White, Parliamentarian

ROLL CALL OF VOTING DELEGATES: Mrs. John R. Hege

REPORT OF REGISTRATION: Mrs. Frederick B. Zaugg

MINUTES OF THE THIRTY-THIRD ANNUAL MEETING: Mrs. John R. Hege

REPORTS OF STATE OFFICERS AND COMMITTEE CHAIRMEN:

NOTE — If there is no objection, the reports of State Officers and Chairmen will be accepted as printed and placed on file, except for reports that require action by the body of the convention and those which must be presented orally, as required by Bylaws, namely: TREASURER, FINANCE CHAIRMAN, FLORIDA AUXILIARY MEDICAL EDUCATION FUND CHAIRMAN, AND REVISION AND RESOLUTIONS CHAIRMAN.

NOMINATIONS FOR 1962 NOMINATING COMMITTEE

NOMINATIONS FOR DELEGATES TO NATIONAL CONVENTION

REPORT OF THE 1961 NOMINATING COMMITTEE: Mrs. Wendell J. Newcomb, Chairman

RECESS FOR COFFEE BREAK AND BALLOTING

PRESENTATION OF DOCTORS DAY AWARDS AND REMARKS: Mrs. Kalford W. Howard, President, Woman's Auxiliary to the Southern Medical Association

MEMORIAL SERVICE: Mrs. John P. Greene

REPORT OF THE COURTESY RESOLUTIONS COMMITTEE: Mrs. Willard R. Gatling

NEW BUSINESS:

REPORT OF TELLERS: Mrs. Charles H. Gilliland

INSTALLATION OF OFFICERS: Mrs. William Mackersie, President, Woman's Auxiliary to the American Medical Association

PRESENTATION OF THE GAVEL AND PRESIDENT'S PIN: Mrs. John M. Butcher

PRESENTATION OF THE PAST-PRESIDENT'S PIN: Mrs. Wendell J. Newcomb

INAUGURAL MESSAGE: Mrs. W. Dean Steward

ADJOURNMENT

CHANGING OF THE GUARD: All outgoing Officers and Committees will present files to their successors.

Technical Exhibit

A feature adding materially to success of the Annual Meeting is the Technical Exhibits. Each firm represented features products particularly interesting to the physician; therefore, make a special effort to visit each booth during the Annual Meeting and register your name with the attending representative.

The exhibits will be open Thursday 11:00 a.m. to 5:30 p.m.; Friday and Saturday 8:30 a.m. to 5:30 p.m., and Sunday 8:30 a.m. to 5:00 p.m.

AUDIO-DIGEST FOUNDATION 106

Glendale, Calif.

Audio-Digest Foundation (a non-profit subsidiary of the California Medical Association) gives the busy physician a time-saving tour through the best of some 600 current medical journals, plus the highlights of scores of national meetings. Time-proven, but still unique, these medical tape-recorded services are now offered in six series: General Practice (issued weekly and biweekly) and Pediatrics, Internal Medicine, Surgery, Obstetrics and Gynecology, Anesthesiology (all issued semi-monthly). The one-hour long tapes are selected and reviewed by a professional Board of Editors. Digest subscribers listen in their car, home or office. The Foundation also offers medical lectures by nationally recognized authorities.

THE BORDEN COMPANY 65

New York, N. Y.

Featuring Bordens new pediatric creme, Methakote, for the treatment of diaper rash in all degrees of severity. Eliminates B ammoniagenes, the causative factor, and prevents staph and other secondary invaders. The added sulphur bearing amino acids accelerate wound healing at site of lesion. Complete information on Methakote and our infant formulas, Bremil and Mull-Soy, is available at Booth 65 through our courteous representatives.

BREON LABORATORIES, INC. 44

New York, N. Y.

Breon is pleased to present Bronkometer, Bronkospray, Bronkephrine, Bronkotabs and Bronkotab Elixir for the prophylactic and therapeutic management of bronchial asthma; Diaparene preparations for the prevention and treatment of ammonia dermatitis; Lanteen products for more reliable family planning and American Ferment preparations—Caroid & Bile Salts Tablets and Al-caroid Antacid.

CHARLES BRUNING COMPANY 13

Teterboro, N. J.

The Charles Bruning Company's exhibit features statement copying. Bruning Copyflex machines produce sharp black-on-white copies of your monthly statements for only one cent each, give patients up-to-date, itemized bills, eliminate all statement typing and addressing.

CARNATION COMPANY 86

Los Angeles, Calif.

Carnation Co. cordially invites you to visit booth 86 where medical representatives will be pleased to welcome members and guests of the Florida Medical Association. Recent literature and information regarding Carnation Evaporated, Carnation Instant Non-Fat, and Carnalac are available. Any question pertaining to our physician-researched material for use in your practice or hospital will be cheerfully discussed.

THE CHLORASEPTIC COMPANY 3

Washington, D. C.

Chloraseptic is a non-toxic, pleasant-tasting mouthwash and gargle specifically designed to destroy infectious bacteria while relieving soreness and pain of the oral and pharyngeal tissues. It possesses profound bactericidal and fungicidal properties and is an effective topical anesthetic. Chloraseptic is indicated in the treatment of pharyngitis, tonsillitis, post-tonsillectomy soreness, smoker's throat, aphthous ulcers, infectious stomatitis, moniliasis (thrush) and Vincent's infection.

THE COCA-COLA COMPANY 7

Atlanta, Ga.

Ice cold Coca-Cola served through the courtesy and cooperation of the Miami Coca-Cola Bottling Company and The Coca-Cola Company.

CORECO RESEARCH CORPORATION 83

New York, N. Y.

The Coret Camera embodies the principle of electronic flash and constant automatic control of such factors as distance, aperture, field and exposure. Now, for the first time, Coreco offers a completely automatic professional clinical camera purposely designed to achieve the ultimate in surface, intra-oral, and intratubular photography. Because of the simplicity of operation, even an inexperienced doctor or nurse can achieve consistently perfect color transparencies.

DESITIN CHEMICAL COMPANY 14

Providence, R. I.

Desitin Ointment: For treatment of burns, ulcers, diaper rash, abrasions, etc.; Desitin Powder: Relieves chafing, sunburn, diaper rash, etc.; Desitin Suppositories and Rectal Ointment: Relieve pain and itching in uncomplicated hemorrhoids, fissures; Desitin Baby Lotion: Protective, antiseptic; Desitin Acne Cream: A non-staining, flesh-tinted "Medicream" for the treatment of acne vulgaris; Desitin Cosmetic and Nursery Soap: Supermild, and Desitin Suppositories with Hydrocortisone: Prompt response to inflammatory conditions in proctitis, severe pruritus, edema.

DOHO CHEMICAL CORPORATION 60

New York, N. Y.

The Doho Chemical Corp. is pleased to exhibit: Auralgan—ear medication for relief of pain in otitis media; also removal of cerumen; Rhinalgan—nasal decongestant free from systemic or circulatory effect. Safe for infants, aged; Otosmosan—non-toxic fungicide-bactericide (gram negative-gram positive) for suppurative and aural dermatomycotic ears; Larylgan—soothing throat spray and gargle for infectious and noninfectious sore throat involvements; Biotosmosan HC—the solution to the "Problem Ear." Antimicrobial, anti-inflammatory, de-inflammatory, antiallergic, antipruritic.

DOME CHEMICALS, INC. 49

New York, N. Y.

Dome introduces Lida-Mantle Creme. Available also with neomycin, hydrocortisone, or both. Systemic steroids are available in Predne-Dome Tablets, K-predne-Dome Tablets, and Delta-Dome Tablets. For inflammatory dermatitides and eczemas micro-dispersed hydrocortisonealcohol in Acid Mantle Creme (pH 4.2) is exhibited as Cort-Dome Creme and its combination with tars, quinoline, neomycin, estrone, etc.

DRUG SPECIALTIES, INC. 6

Winston-Salem, N. C.

I-IRON- A timed disintegrating ferrous fumarate capsule for maximum assimilation without G.I. irritation on a one-capsule-per-day dosage. PREDLON- The true timed disintegrating corticosteroid for maximum assimilation, with less danger of side effects with a lower maintenance dose.

EATON LABORATORIES 102

Norwich, N. Y.

New Furadantin® (brand of nitrofurantoin) Sodium for intravenous use—an alternative route of administration Furadantin in patients when parenteral medication is indicated. Furadantin Sodium for intravenous use fills a need for a parenteral form in the treatment of urinary tract infections, such as pyelonephritis, pyelitis, cystitis—and in selected systemic infections—which have failed to respond to other antibacterial therapy.

FLINT, EATON & COMPANY 109

Morton Grove, Ill.

Featured products are Ferrolip, Synthroid. Ferrolip is a chelate complex of iron which is clinically effective and well tolerated. Ferrolip also provides a maximal factor of safety against the possibility of iron poisoning in case of accidental overdosage. Synthroid Tablets contain sodium levothyroxine, the active principle of the thyroid gland, prepared synthetically in pure crystalline form.

FLORIDA BRACE CORPORATION 2

Winter Park, Fla.

The Florida Brace Corp. exhibits the Jewett Hyperextension Back Brace, standard and fusion models, for treatment of spinal conditions requiring positive hyperextension such as simple compression fractures, osteoporosis, Marie Struempell's disease, adolescent epiphysitis and post lower fusion where minimal motion in the fused area is desired. They also will exhibit various types of adjustable cervical collars for extension, flexion or stabilization.

GEIGY PHARMACEUTICALS 42

Yonkers, N. Y.

Geigy cordially invites members and guests of the Association to visit its exhibit. The exhibit features important new therapeutic developments in the management of inflammation, as well as current concepts in the control of hypertension and edema; depression; obesity, and other disorders, which may be discussed with physicians and representatives in attendance.

JOHNSON & JOHNSON 17

Brunswick, N. J.

Johnson & Johnson will display the latest improvements in surgical dressings, as developed by the Johnson & Johnson Research Laboratories. Of special interest is Surgical Absorbable Hemostat, a major advance in the control of hemorrhage which does not depend upon the normal clotting mechanism. Dermicel Surgical Tape, a special purpose dressing tape for patients with unusual adhesive tape sensitivity, is also of particular interest. Other products, designed for your office, hospital or patient use, are also displayed. You will find well informed representatives pleased to discuss these products or provide information on any other items made available by the world's largest manufacturer of surgical dressings and baby products.

ELI LILLY AND COMPANY 64

Indianapolis, Ind.

You are cordially invited to visit the Lilly exhibit located in space number 64. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

LLOYD BROTHERS, INC. 16

Cincinnati, Ohio

Welcome to the Lloyd Brothers exhibit. Our professionally training sales representatives will be pleased to greet you and discuss the merits of our products in your practice. Of particular interest will be a new booklet on erythropoietin, the erythropoietic hormone.

J. A. MAJORS COMPANY 95

Dallas, Texas

The latest publications of the W. B. Saunders Co. will be on display for your examination. Edwards—Atlas of Acquired Diseases of the Heart; Fontana & Edwards—Congenital Cardiac Diseases; Pillsbury—Manual of Cutaneous Medicine; Beckman—Drugs (New 2nd Edition); 1961 Current Therapy; Surgical Practice of the Lahey Clinic (New 2nd Edition); and Williams—Clinical Endocrinology (New 3rd Edition).

MALTBIE LABORATORIES DIVISION
WALLACE & TIERNAN, INC. 30

Belleville, N. J.

Maltbie Laboratories features the unique tranquilizer compound, DORNWAL, that works for greater therapeutic effect without causing sedation. Also displayed are CALDECORT, an antifungal, antibacterial, anti-inflammatory dermatologic ointment; DESENEX, for athlete's foot; NESACAINE, a safe, potent and rapid-acting local anesthetic; CHOLANS, for hepato-biliary dysfunction; and CALDESENE MEDICATED POWDER for diaper rash.

MEAD JOHNSON & COMPANY 71

Evansville, Ind.

The Mead Johnson exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

MEDCO PRODUCTS COMPANY, INC. 56

Tulsa, Okla.

Presenting the Medco-Sonlator. Providing a new concept in therapy by combining muscle stimulation and ultra sound simultaneously through a single three-way sound applicator. The Medco-Sonlator is a distinct advance in the effectiveness of physical therapy in your office or hospital. A few minutes spent in our booth should prove of value to your practice.

MEDICAL PROTECTIVE COMPANY 100

Fort Wayne, Ind.

As the number one malpractice insurer, The Medical Protective Co. offers unexcelled coverage. With exceptional proficiency in defense, so essential to the doctor's protection today, its experience in successfully handling 81,000 claims and suits during 62 years of Professional Protection Exclusively is unparalleled in the professional liability field.

THE WM. S. MERRELL COMPANY 21

Cincinnati, Ohio

A summary of mounting clinical evidence attesting to the effectiveness of MER/29 in patients with hypercholesterolemia and related conditions will be presented by Merrell. Up date your knowledge of MER/29 by stopping briefly at the Merrell display. Salesmen will summarize the extensive results of MER/29 therapy for you and answer questions you may have. Best wishes for a most enjoyable convention.

C. V. MOSBY COMPANY 36

St. Louis, Mo.

New knowledge, new ideas, new research and techniques—all are waiting for you in the newest Mosby books for 1960 and 1961. Come in. Look over these books at your leisure and convenience. If you wish his assistance, our experienced representative will be happy to discuss any book with you.

V. MUELLER & COMPANY 78

Chicago, Ill.

We are now fully operational in Florida with our new office and warehouse facilities located at 1951 Delaware Parkway in Miami (Newton 3-6711). We hope you will stop by our booth and say "hello." A complete instrument display will be there for your convenience.

MUTUAL BENEFIT LIFE INSURANCE COMPANY 24

Newark, N. J.

"Financial Planning for the Physician." Trained representatives associated with General Agents Truman M. Huffman, C.L.U., Jacksonville, and Alfred J. Lewallen, C.L.U., Miami, will supply information about estate planning, NSLI disability benefits, other aspects of life insurance. Tax Calculator Slide Rule available at booth without obligation. Register for "Estate Planning for Physicians," other booklets.

ORGANON, INC. 52

West Orange, N. J.

Physicians are cordially invited to visit the Organon booth for information on useful therapeutic specialties. Included among these will be: Durabolin, a safe, potent, long-acting anabolic stimulant indicated in all conditions where a tissue-building action is desired. Durabolin provides its potent tissue-building effects without the the drawbacks and dangers characteristic of tissue-building steroids. No masculinization occurs in recommended dosages. No progestational effects can occur. Administered only once each week. Organon representatives will gladly discuss these specialties with all interested physicians.

ORTHO PHARMACEUTICAL CORPORATION 28

Raritan, N. J.

At booth 28, Ortho is proud to present the most complete line of products for the control of conception. Representatives on hand are showing the Ortho Arcing Spring Diaphragm, the most recent advance in this field. For those patients not suited to the diaphragm method, Ortho representatives will be happy to discuss the use of Delfen Vaginal Cream and Preceptin Vaginal Gel for use with an applicator.

PARKE, DAVIS & COMPANY 67

Detroit, Mich.

Medical service members of our staff will be in at-

tendance at our booth to discuss important Parke-Davis specialties which will be on display.

PFIZER LABORATORIES 104

Brooklyn, N. Y.

Professional service representatives from Pfizer Laboratories will be pleased to have you in attendance at their booth to discuss the latest products of Pfizer research.

WM. P. POYTHRESS & COMPANY, INC. 73

Richmond, Va.

A cordial welcome awaits you at the Poythress booth which will feature Synirin, outstanding and distinctive new analgesic, and Mudrane, effective, balanced formula for bronchial asthma. Solfoton, Solfoserpine, Panalgesic and Trocinate will also be featured. Your request for literature and professional trial supplies of any Poythress product is invited.

R. J. REYNOLDS TOBACCO COMPANY 115

Winston-Salem, N. C.

Welcome to the R. J. Reynolds Tobacco Co. exhibit. You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of Camel, Winston Filter, Menthol Fresh Salem, or Cavalier, King Size Cigarettes.

A. H. ROBINS COMPANY, INC. 20

Richmond, Va.

Nine out of ten of your nasal allergy patients may benefit from your visit to the Robins booth to hear about Dimetane. Its anti-histaminic potency and paucity of side effects are unsurpassed. Robins representatives will also gladly explain the advantages of Donnagel (in diarrhea), Ambar (for overweight), Naclex (in edema and hypertension), and other ethical Robins products.

SANBORN COMPANY 12

Waltham, Mass.

New electrocardiographs of advanced design and function, as well as latest models of other instruments for diagnostic use, will be displayed and demonstrated at the Sanborn Co. booth. Demonstrations and/or data will also be available on Sanborn instruments for biophysical research—single and multichannel recording systems, monitoring oscilloscopes and physiological transducers. Qualified Sanborn representatives will be pleased to answer questions and assist you with technical problems.

SANDOZ PHARMACEUTICALS 29

Hanover, N. J.

Sandoz Pharmaceuticals cordially invites you to visit our display: Mellaril: the first potent tranquilizer with a selective action (i.e. no action on vomiting centers). This unique action gives specific psychic relaxation with safety at all dosage levels. Plexonal: preferred daytime sedative-relaxant. New—Syntocinon Nasal Spray for intranasal application of synthetic oxytocin (Syntocinon). Activates the milk-ejection reflex to stimulate milk let-down. Overcomes some of the complications associated with lactation, e.g. engorged, painful, tender or distended breasts due to milk retention and stasis or the circumscribed, painful induration of incipient mastitis. Accelerates involution of the uterus.

SCHERING CORPORATION 15

Bloomfield, N. J.

You are cordially invited to visit the Schering technical exhibit where our representatives will discuss the following products: Fulvicin, the first oral antifungal antibiotic for ringworm; Naqua, effective new oral diuretic and antihypertensive; Deronil, the corticosteroid of choice; and Diloderm, first chlorinated steroid with specific topical effectiveness.

JULIUS SCHMID, INC. 111

New York, N. Y.

An interesting and informative exhibit featuring Immolin Vaginal Cream-Jel for use without a diaphragm; Ramses Flexible Cushioned and Bendex Diaphragms; Ramses Vaginal Jelly; Vagisec Jelly and Liquid for vaginal trichomoniasis therapy; and XXXX (Fourex) Skin Condoms, Ramses, Sheik and Esquire Rubber Condoms for the control of trichomonal reinfection.

G. D. SEARLE & COMPANY 84

Chicago, Ill.

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research. Featured will be our new Aldosterone-Blocking Agent for edema or ascites, Aldactone.

SHERMAN LABORATORIES 113

Detroit, Mich.

Elixophyllin: Severe asthmatic attacks are not merely relieved, but terminated in 10 to 20 minutes by Elixophyllin, given orally.

Persistin: A long-acting, non-narcotic analgesic. Prescribed as a single dose, Persistin provides therapeutic salicylate levels up to eight hours and permits avoidance of narcotics and hypnotics for many patients.

THE STUART COMPANY 108

Pasadena, Calif.

A cordial invitation is extended to all members and guests attending this meeting to visit the Stuart Co. booth. Specially trained representatives will be in attendance to answer your questions on new products developed in our new and modern laboratories.

UPJOHN COMPANY 47

Kalamazoo, Mich.

Professional representatives of The Upjohn Co. are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

WESTWOOD PHARMACEUTICALS 107

Buffalo, N. Y.

Westwood invites physicians to stop by their booth to discuss their unique dermatological products: Fostex Cream, Fostex Cake, Lowila Cake, Lowila Emollient, Sebulex, Fostril and Alpha-Keri. These products are particularly suitable for personal use by physicians.

Volume XLVII
Number 11

Diagnostic Clinic: Digestive Disease

Case Summary

This summary and the one following on cardiovascular disease are the cases to be discussed at the two Diagnostic Clinic beginning at 9:00 a.m. Friday, May 26, at the Annual Meeting of the Florida Medical Association at Bal Harbour, Miami Beach. These two Diagnostic Clinics will comprise the program for the First Scientific Assembly of the Annual Meeting.

First Admission

History.—A 49 year old white salesman was seen for the first time at the Coral Gables Veterans Hospital in October 1958, when he was admitted with the chief complaint of nausea, vomiting and pain in the right upper quadrant of four days duration. The pain was sharp, and moderately severe. It radiated to the right subscapular area and it was associated with nausea and frequent emesis. There was no hematemesis, fever, chills, or melena. The patient noted no change in the color of his stool but had noticed dark urine during the four days prior to admission. There was no history of alcoholism or dietary intolerance. He complained of no symptoms other than those relating to the digestive tract.

Past Medical History.—(1) Coronary thrombosis in 1946 and 1956. (2) In 1953 he had a diagnosis of duodenal ulcer established by x-rays made in a New York hospital. He had followed a bland diet with no subsequent ulcer symptoms. (3) In 1957 he had an episode of "viral hepatitis."

Physical Examination.—Temperature 100.8°, blood pressure 120/75 mm., pulse 80, regular. The patient appeared well developed, well nourished, and in acute abdominal distress. A slight degree of scleral icterus and marked guarding and tenderness in the right upper quadrant were the only significant abnormal findings.

Laboratory Data.—Hgb. 14.8 gms., WBC 31,600 with a shift to the left. The urine analysis was positive for bilirubin. The blood urea nitrogen, serum amylase, cholesterol, and prothrombin time were within normal range. Liver function tests revealed: total bilirubin 4.6 mgs. per cent, alkaline phosphatase 5.9 B.U., cephalin flocculation 2+ in 24 hours, and thymol turbidity 1.1 units. Electrocardiogram revealed evidence of an old posterior wall infarction.

X-ray Studies.—The chest x-ray demonstrated evidence of a bilateral basal pneumonitis which subsequently cleared on a repeat examination. A plain film of the abdomen revealed no radiopaque calculi and no abnormal gas pattern. An oral gallbladder study and intravenous cholangiogram did not visualize either the gallbladder or the common duct.

Course.—The patient was treated conservatively with analgesics, nasogastric suction, intravenous fluids and anticholinergic medication, with a working diagnosis of acute cholecystitis and cholelithiasis. The patient rapidly responded with subsidence of symptoms and icterus. He was discharged ten days after admission free of symptoms and fever. An elective cholecystectomy was recommended but the patient declined.

Second Admission

The patient enjoyed good health after his discharge from the hospital in 1958 until December 1960 when he had a sudden onset of chills and fever. In addition he developed a persistent dull ache in the right upper quadrant, radiating posteriorly to his right scapular area. Later that day he became nauseated and vomited immediately following a meal. His sclerae were noted to be icteric the following day while he continued to have pain and nausea, whereupon he was readmitted to the Coral Gables Veterans Hospital. There had been no change in bowel habit, exposure to infectious disease or hepatotoxic drugs, and no recent injections.

The examination on admission revealed a slightly jaundiced white male with a temperature, pulse and blood pressure all within normal. There was marked right upper quadrant tenderness with guarding on palpation of the abdomen. There were no other positive physical findings.

Laboratory Data.—WBC 20,491 with a slight shift to the left, Hgb. 16.8 gms., hematocrit 50 vol. per cent; urine analysis was normal except for a bilirubinuria; SGOT 119 units; serum bilirubin 4.7 mgs. per cent. The blood urea nitrogen,

Appreciation is expressed to Dr. Joel Fyvolent, Resident Physician, VA Hospital, Coral Gables, for his help in preparation of this case report.



Figure 1



Figure 2

glucose, proteins, and prothrombin time were all within normal range. The serum leucinaminopeptidase was 450 units (upper limit of normal 200). Two days after admission the white blood count was 29,350 with a marked shift to the left and no change in the hemoglobin and hematocrit. The alkaline phosphatase was 7.1 B.U. and serum amylase was normal. Electrocardiogram, chest film and plain film of the abdomen all were reported normal.

Course.—The patient was treated conservatively with bed rest, analgesics, low fat diet and antibiotics. After 72 hours his abdominal tenderness had disappeared. Jaundice subsided along with general improvement. Approximately two weeks after admission a combined oral and intravenous cholangiogram (fig. 1) revealed dilatation of the common duct and a normal gallbladder shadow with no filling defects. The following week an upper gastrointestinal x-ray (fig. 2) study demonstrated a large diverticulum in the postbulbar area and two smaller diverticula in the third portion of the duodenum. No ulcer crater or delay in gastric emptying was found. A celiotomy was performed 20 days after second admission.

Chester Cassel, M.D.

Volume XLVII
Number 11

Diagnostic Clinic: Cardiovascular Disease

Case Summary

A 47 year old unemployed laborer was admitted to the Teaching Hospital of the University of Florida College of Medicine on Jan. 31, 1960, with principal complaint of pain in the left upper back of one year's duration. The present illness began in June, 1957, two and a half years prior to being admitted to the hospital.

In June, 1957, the patient had an abrupt onset of numb, burning pain over the sternum and in the upper abdomen which persisted and radiated down the ulnar surface of the left arm and through to the left scapula. The pain was relieved in one to two hours by hypodermic injection. There were no other symptoms other than profuse diaphoresis. On limited activity, he remained asymptomatic for a week. Then, however, he had an identical yet more severe episode of pain and was hospitalized in another city for three weeks with oxygen, sedation and nitroglycerin being administered. Electrocardiograms following the first episode of pain and during this period of hospitalization revealed less than 1 mm. elevation of the S-T segment and tiny Q waves in leads II, III, AVF and were interpreted as being normal. Following hospitalization the patient had remained on limited activity and had been well for approximately a year. He then noted the onset of a burning, aching pain in the left upper back along the inner border of the scapula. Initially, the pain always was related to exertion, was less than 10 minutes in duration and was relieved promptly by sublingual nitroglycerin. Accompanying the pain in the back was an ache in the left arm and wrist. There was a progressive

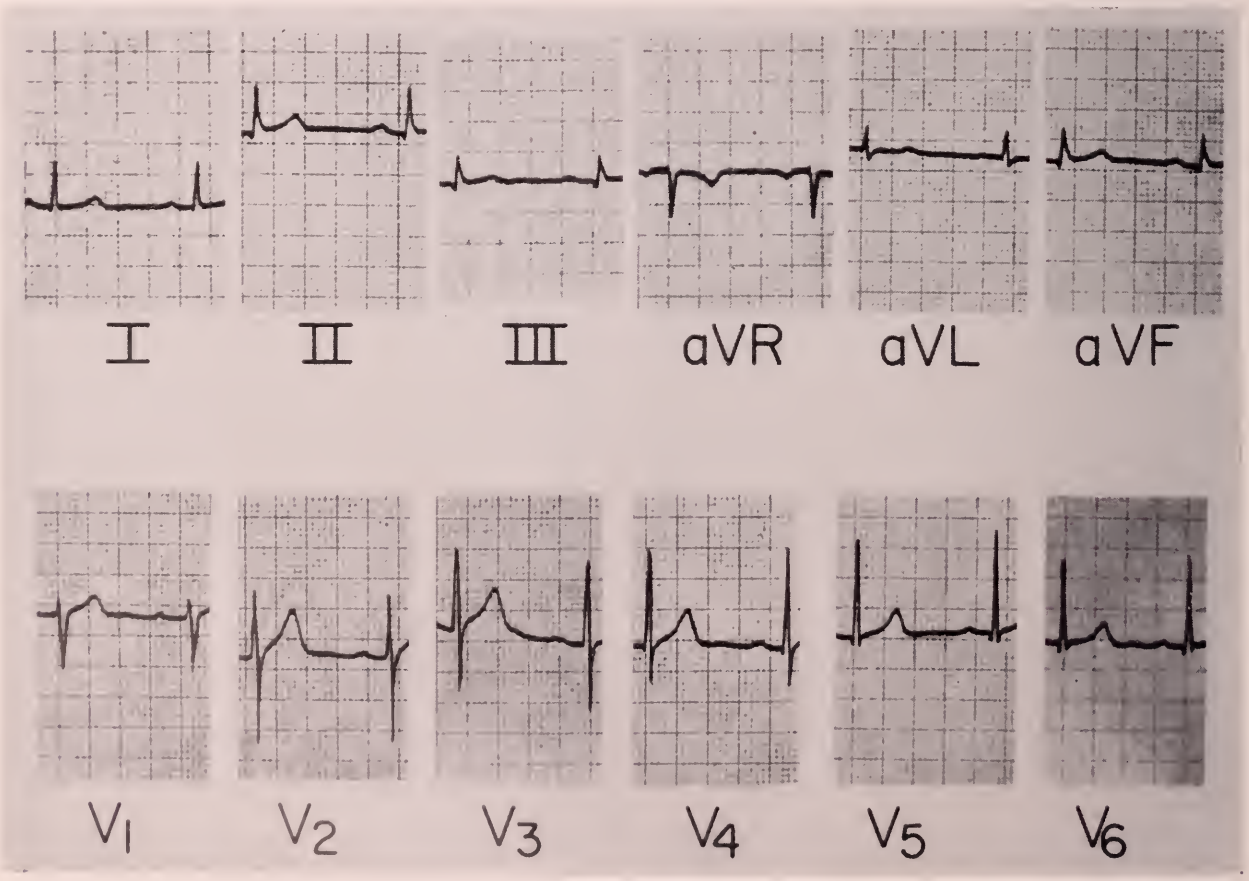


Fig. 1.—Electrocardiogram from the referring physician taken on June 25, 1957. Leads I, II, III on the left and AVR, AVL, AVF on the right.

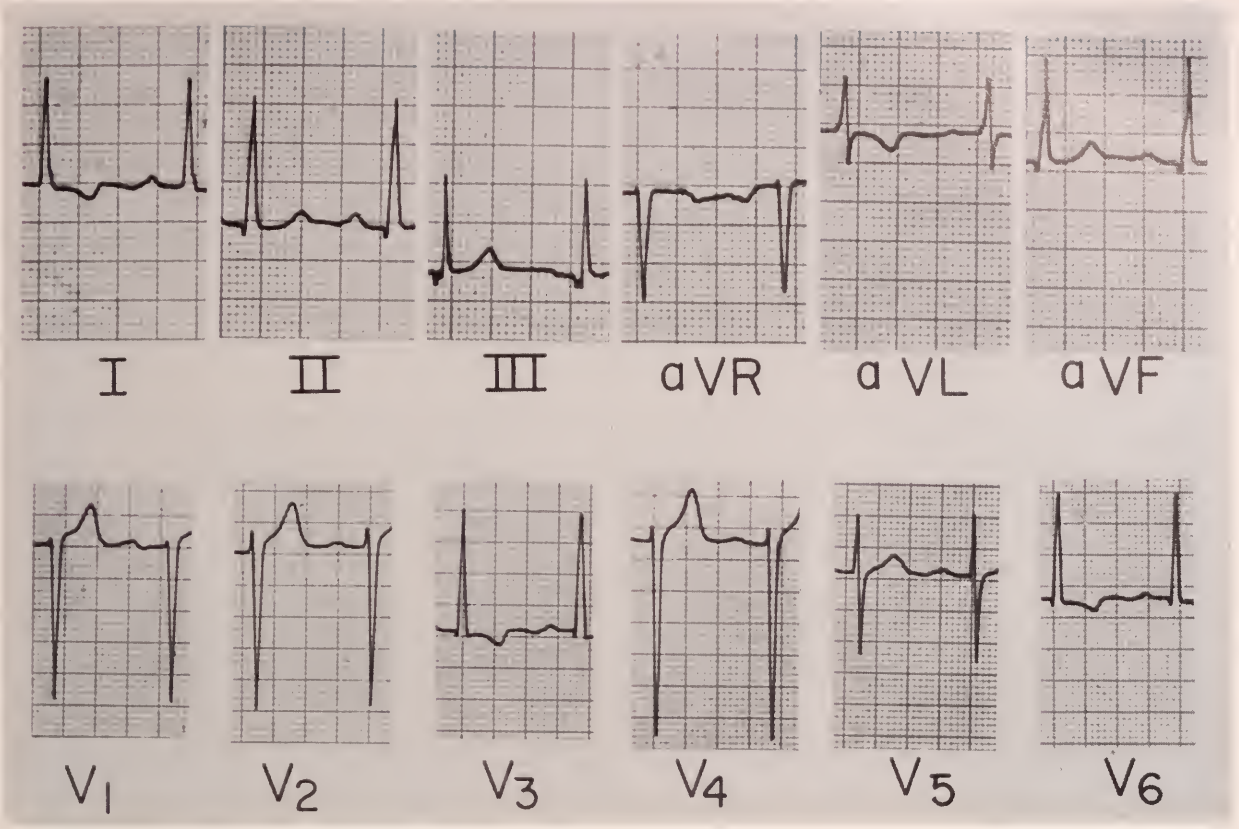


Fig. 2. — Electrocardiogram taken on Feb. 1, 1960 on admission to the University of Florida Teaching Hospital.

increase in the frequency and severity of the pain and over the six months preceding admission to the Teaching Hospital, he began having episodes of pain which would awaken him at night and occasional episodes during the day while at rest. Excitement and cold similarly would induce pain. No history of dyspnea, weakness, wheezing, edema or orthopnea was obtained.

In the family of twelve siblings and parents, there was no known history of cardiovascular disease or familial illnesses.

The past medical history revealed that the patient had had jaundice in childhood, but there was no other significant illness. Before the onset of the present illness, he always had been physically active, and his weight had remained stable.

Physical examination revealed a well developed, somewhat overweight middle aged man who did not appear ill aside from striking arterial pulsations in the neck. The vital signs were normal other than a blood pressure of 115/45 in the right arm and 140/50 in the left arm. The skin was clear and there was no palpable lymphadenopathy. Examination of the eyes revealed the vision to be normal; the lens were clear and the retinal vessels were normal. Ear, nose and throat examination was normal. The neck veins were flat and the chest was symmetrical and moved normally; the lungs were clear. The heart was enlarged with a rocking, forceful apical impulse in the fifth intercostal space almost at the anterior axillary line. The second heart sound was of tambour quality in the aortic area; there was no ejection click. Grade IV systolic and diastolic murmurs were maximal in the third right intercostal space along the sternal border but widely heard over the remaining precordium and out to the apex and in the axilla. The systolic murmur was a decrescendo medium pitched murmur and the diastolic was a blowing higher pitched murmur. The rhythm was regular and there were no gallops. The peripheral arterial pulses were all bounding although the right radial pulse was somewhat weaker than the left. There were pistol shot sounds over the femoral artery and capillary pulsations were noted. The remainder of the examination was entirely normal.

The hemoglobin, white count, differential, urinalysis, BUN and blood sugar were normal. Electrocardiogram revealed increased voltage and a posterior shift of the QRS forces giving deep S waves over the anterior precordium indicative



Fig. 3. — Left anterior oblique roentgenogram of the chest taken on Feb. 1, 1960 on first admission to the University of Florida Teaching Hospital.

of left ventricular hypertrophy. There were also S-T and T vectors to the right giving S-T depression in leads I, V5 and V6 and T inversions in the same leads indicative of left ventricular strain. Fluoroscopy and x-rays of the chest revealed considerable enlargement of the left ventricle and dilation of the ascending aorta but there was no calcification in the aorta or in the valves. The aortic pulsations were quite prominent.

On Feb. 3, 1960, the patient was sent for surgery utilizing cardiopulmonary bypass.

In May, 1960, the patient again was admitted to the Teaching Hospital for repair of a false aneurysm of the left femoral artery, but otherwise has done well. He has continued having some pain beneath the left scapula and in the left arm with exertion but the pain is less frequent. There has been no nocturnal pain. There has been no indication of heart failure and his exercise tolerance has improved. On his last visit on Oct. 19, 1960, the blood pressure was 120/60. The heart size was unchanged but the murmurs were less intense.

GEORGE T. HARRELL, M.D.



Fig. 4. — Anteroposterior roentgenogram of the chest taken on Feb. 1, 1960 on first admission to the University of Florida Teaching Hospital.

PRESIDENT'S PAGE

Above and Beyond

In all ages, in all civilizations, there have been men, not necessarily leaders or appointed or elected officials, who served a group of which they were a part for the simple reason that a job needed to be done. They attacked problems because of an inner urge to see them properly solved, much as great mountain climbers scale dangerous peaks because the peaks are there. They are moved not by self-righteousness, daring, or the desire for fame or recognition. Such men make history.

There are men of this caliber in many great, constructive and beneficent organizations. I hold the Florida Medical Association to be one of these groups, and I believe there is a handful of dedicated men within our Association who fall within the category of those who serve above and beyond the call of duty. I would dedicate to them this "President's Page," the last that I shall be privileged to write.

To those who give of their time, talents, and material goods, voluntarily, unstintingly, frequently at a sacrifice unknown to most of us, we are eternally grateful. They are known to our members, often to the American Medical Association, and to many segments of the public at large. They are taken for granted by the majority of us who sit complacently on our assets while dragons need to be slain.

This is feeble recognition of their monumental service, and yet, I would also make it a plea to the great numbers in our membership who are discontented with things as they are or as they portend to be but are content to give only lip-service to change and let someone else fight their battles. The effectiveness of an aroused and aggressive organization as ours can be has only been demonstrated once within recent memory, when by contributing to a change in a political office we were able to influence and prevent a change in political philosophy inimical to the American way of life and the healthy practice of American medicine. The present threat, being insidious, is even more dangerous. It is past time for the sleeping giant that is our informed membership to awake and do battle.

God give us men! A time like this demands
Strong minds, great hearts, true faith, and ready hands;
Men whom the lust of office cannot buy;
Men who possess an opinion and a will;
Men who have honor; men who will not lie;
Men who can stand before a demagogue
And damn his treacherous flatteries without winking;
Tall men, sun-crowned, who live above the fog
In public duty and in private thinking.

—Josiah Gilbert Holland.

Leo M. Wachtel

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Osteoporosis—A Résumé

Osteoporosis is probably the most common disorder of bone, but its recognition as such has largely developed within the past 25 years. Clinical recognition of the frequency of this disease stems directly from the widespread use of x-rays, and its radiologic features are now well known. The diagnosis of osteoporosis, however, requires precise criteria for it may co-exist with or be simulated by other diseases causing radiologically "thin" bones.[1] As presently understood, the diagnosis signifies a particular type of reduction in the amount of bone characterized by a decrease in the thickness of bone cortex and a reduction in number and width of trabeculae.[2] On light microscopy the involved bone appears normally mineralized and chemical analyses reveal the percentage of bone ash and the calcium-phosphorus ratio to be the same as in normal bone.[3] Microradiograms of osteoporotic bone illustrate the thin cortex comprised of a reduced number of apparently normal osteones and the presence of large resorption cavities which have not been filled by new bones.[4] Remarkably small forces may cause fractures in osteoporotic subjects, whose bones may be easily crushed at necropsy.[5]

Although osteoporosis occurs primarily in elderly subjects, particularly women, it may occur in young persons of either sex unassociated with other disease (idiopathic osteoporosis). Moreover, a variety of clinical disorders may be accompanied by the development of osteoporosis at any age. Involvement of bone is usually generalized, being most marked in the vertebrae and least evident in the skull, but the process may develop locally in an extremity immobilized in plaster or following nerve injury. Bone porosity may also appear adjacent to painful joints or with certain types of vasomotor dysfunction (Sudeck's atrophy).

PATHOGENESIS.—Since the initial observations by Pommer[6,7] and Schmorl[8,9] defining the microscopic and macroscopic features of osteoporosis, a number of theses have been proposed to explain the pathogenesis of this disorder. It was immediately appreciated that osteoporosis occurred most often and most severely in the aged, so senescense per se was suggested as being etiologically significant with physical inactivity a contributory factor.[7-10] Consistent with this proposal was Ingalls'

report[11] of decreasing skeletal weight, excepting the skull, with increasing age. Osteoporosis, however, was found to be neither limited to nor universally present in the elderly. Meulengracht and Meyer[12] considered inadequate diet or malabsorption to be of major importance in the genesis of osteoporosis, but it was soon demonstrated that the dietary habits and nutritional status of afflicted patients did not differ from those of healthy subjects of comparable age.[13, 14]

Albright, Smith and Richardson[13] re-emphasized the views of the German pathologists that impaired growth of bone rather than defective mineralization was causative in osteoporosis and suggested that hormonal insufficiency, particularly that exemplified by the postmenopausal state, was of paramount importance in the development of this disease. This latter concept was thought to account for the frequency of osteoporosis in the elderly female, although, admittedly, the demands of pregnancies or inadequate diets might add to the severity of the disorder. In a series of classical studies[15, 16] the Massachusetts General Hospital workers and others[17] demonstrated the effectiveness of estrogens and androgens in promoting calcium and phosphorus retention in osteoporotic males and females. Despite an improved sense of well-being in patients so treated, radiologic evidence of increased bone density has been scant or absent even after years of continuous therapy.[18]* Furthermore, osteoporosis does not necessarily ensue after oophorectomy or in the naturally occurring menopausal state.[16, 20]

The foregoing observations prompted re-evaluation by balance techniques of the calcium requirements in adults, especially the elderly.[21-27] The results of these studies may be summarized as follows: (1) most subjects receiving less than 400 mg. of calcium daily excrete more of this element than they retain; (2) some subjects require more than 800 mg. of calcium daily to achieve a positive balance; (3) many elderly subjects apparently absorb calcium as efficiently as younger adults; and (4) vitamin D in large dosage (25,000 I.U. per day) may enhance calcium retention.[25] Such data are worthy of emphasis when it is realized that diets devoid of dairy products generally contain approximately 300 mg. of calcium, an amount insufficient for maintenance of a positive balance by most adults. Therefore, the suggestion has been reintroduced that prolonged inadequate intake of calcium is a major factor in the development of osteoporosis in the elderly.[28] There is difficulty in reconciling this suggestion with the concept that the essential defect in osteoporosis is impaired bone matrix formation. The latter concept is supported by demonstrated abnormalities in protein metabolism or connective tissue structure, and thus possibly matrix formation, in many of the clinical disorders which may be accompanied by osteoporosis, for example, Cushing's syndrome, scurvy, nephrosis, diabetes mellitus, osteogenesis imperfecta, and the Ehlers-Danlos syndrome.** Sufficient evidence is not yet available to resolve these divergent views, but it is conceivable that both concepts will prove applicable. There is much to be learned about bone formation and resorption before one can expect a clear understanding of the genesis of osteoporosis. The effect of prolonged calcium deficiency on matrix formation and the possibility of reduced growth hormone in the elderly modifying bone formation rates need further study.

There is one aspect of the problem of osteoporosis in the elderly which merits special comment. This disorder is recognized with much greater frequency in the female than in the male. Does this mean that the causative process is more active in postmenopausal women than men? One wonders if the frequency in the elderly female is not simply due to the less dense skeleton of adult women as compared with similarly aged men, and subsequent equal increments in bone porosity would result in sufficiently thin bone in the female to be classified as osteoporotic, whereas, the male requires a much more extensive thinning to attain the same degree of radiologic porosity.

PHYSIOLOGY.—Osteoporosis has been considered by some to represent bone atrophy with the implication that such bone is relatively inactive. It has been demonstrated, however, although indirectly, that osteoporotic bones accept increments in calcium in amounts approaching that of normal bones.[30, 31] Furthermore, several excellent studies with radioactive tracers[32, 33] indicated that in osteoporotic subjects the exchangeable pool of body calcium was not reduced and, in addition, that bone formation rates were normal. Such observations signify that the functional units of bone, the osteones, although reduced in number, are normally active.

THERAPY.—Current therapy of osteoporosis is largely empirical. The correction or control of

*The patient reported by Sherman[19] provides a unique exception.

**Although the bones in thyrotoxic subjects may become radiologically "thin," histological studies reveal that osteitis fibrosa rather than osteoporosis is the predominant process in such patients.[29]

disorders which may initiate osteoporosis and mobilization of inactive patients is undoubtedly a beneficial measure. Also, it is logical to provide afflicted subjects with an adequate intake of calcium (a minimum of 800 mg. daily). The form in which this element is made available is important, its absorption from milk being demonstrably better than when certain calcium salts are used.[34]

As yet there are too few observations on the effectiveness of moderately large doses of vitamin D (25,000 I.U. per day) in promoting calcium retention in osteoporotic subjects. Supplements of physiologic amounts of this vitamin (1,500 I.U. per day) to adult patients on normal diets have not proved beneficial, and dosage with 50,000 I.U. or more per day may be followed by marked hypercalciuria, or hypercalcemia.[35] Results of experimental studies with strontium suggest that despite clinical reports,[36] this element may not be beneficial in osteoporosis.[37] Intravenous albumin promotes calcium retention, but is hardly practical.[38]

Should the elderly patient with osteoporosis who has bone pain and tenderness or who has had spontaneous fractures be given estrogens, androgens or other anabolic agents to promote calcium retention? As most body calcium exists in the skeleton, it is inferred that retained calcium localizes in bone, a likely inference that remains to be proven. Unfortunately, much of the calcium and phosphorus retained by patients treated with androgens or estrogens is apparently soon excreted on cessation of therapy.[16]

It is intriguing that estrogen deficiency has been postulated to lead to inadequate bone protein (matrix) formation in postmenopausal osteoporosis; yet its administration, even in pharmacologic doses, usually does not induce significant nitrogen retention.[16, 17, 26, 39] Perhaps sex hormones enhance mineralization of existing osteones without affecting matrix formation. Nevertheless, in the elderly osteoporotic patient treated with physiologic amounts of these substances a sense of well-being often develops and judicious use seems warranted. It remains to be shown that combinations of physiologic amounts of sex hormones are advantageous, and in dealing with a given patient it is simpler to use the hormone appropriate to the sex of the patient.

Obviously, knowledge of this disorder is meager. It is hoped that present and future studies will provide better understanding of osteoporosis and its possible relationship to the process of aging.

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PATIENTS WITH IMPENDING CARDIAC DECOMPENSATION

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PATIENTS WITH EMOTIONAL AND NERVOUS DISORDERS

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Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. In the treatment of allergic respiratory disorders, dosage should be individualized and kept at the lowest level needed to control symptoms. Dosage should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

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Young America Speaks

A beacon for the future in these days of dejection when it seems that all around us are turning to socialistic largess and dependency, the address reprinted here seems an exciting and refreshing reaffirmation of the individualistic spirit of young America. It is heartening to note that the philosophy and the ideals which founded this country continue to burn brightly in at least some of its young people's breasts.

Mert has produced a masterpiece which cannot help inspiring us all, and cannot help being instrumental in influencing the thinking of the youth of our country. Measured by his standards, many of us in adult life must feel uncomfortable when we review our past performances—our motives and our ideals—but with such young men, our heritage of free enterprise and "Individual Excellence" can never be lost.

J. W. A.

"Seek Individual Excellence"

MARVIN LEE (MERT COOPER)

PAMPA, TEXAS

To be my best. That is my job. No man can do it for me. Neither can I do it by myself. I borrow from man's wisdom, and I grow. I learn of success and failure from others, and I improve. I am a person. I began as a human being. Humanity is God's masterpiece of Creation. I live in America—the earth's finest monument to God's plan. In my land, mine is not a struggle but a choosing of opportunities. In my land, I find good reason to increase in knowledge, strive for perfection, and improve in spirit.

I am a part of the business of America. My mind, muscle, and heart are hired for a wage. I do my work and I am paid. I spend my wages and receive products worth a king's ransom in other lands. I have the wages to live on, the challenges to grow on, and the opportunities to reach for. I am limited only by myself. No man restrains my honest increase, except me. I will demand that I mold, shape, sharpen, and refine my talents in the work I choose to do. I seek individual excellence.

I am a part of the Government of America. I am born to the management team of the world's greatest enterprise. America is a vast operation. My first twenty-one years I spend as an apprentice. I learn about my role as a citizen—as a part of Government. Nowhere would I count for as much as I do in America. I am an individual, the most sacred of all living things in my land. I am not a slave to my America. I own America. She is what I help her to be. I owe to all men of my time, my honest conviction; to all men before me, my respect for their memory; and, to all men after me, my example of patriotism. This is my job as one who will help to run a big country. I will require of my mind, wisdom; of my heart, judgment; and of my soul, patience. I seek individual excellence.

I am part of the heart of America. America cares about me, and I owe her my deepest affection. Those who have give for those who have not. When tragedy strikes, America does not ask the color of a man's skin, the drift of his politics, or the turn of his faith. He is without food, feed him. He is without garments, clothe him. He is injured, treat him. America struggles against ignorance and disease. She builds schools where we may learn; hospitals where we may be healed; museums where we may glory in our past, and laboratories where we may discover our future. I am a pulse in the beat of America's heart; a drop in the stream of her devotion to brotherhood; and a throb in the rush of her great kindness. I seek individual excellence.

I am a part of the soul of America. I stand on a foundation of God, as each man understands Him. I am the knee bent in prayer; the hand held out in comfort; the head erect to hear His voice, and the form of God Himself. America is

Winner: Oratorial Contest, Texas-Oklahoma District Key Club Convention, Dallas, Texas, April 8-10, 1960.

Born in Amarillo, Texas, October 17, 1941, the author gained his public school education in Lefors and Pampa, Texas schools. He was graduated from Pampa High School in May 1960, and enrolled in McMurry College at Abilene, Texas, in September, 1960.

Reprints of his award-winning address may be obtained from Cooper Scholarship Fund, 2331 Navajo Road, Pampa, Texas.

a mighty Cathedral born of man's dreams. Immortality sings from her timeless hills; eternity beckons from her graceful spires, and the infinite tells me: "This is not all. This is but preparation for time without todays or tomorrows." I seek individual excellence.

Join me friend, stranger, unknown, and unborn. Join me in our vast eternity, and let us work together for excellence. One day we will know. Our excellence, or the lack of it, haunts our every step. To be my best. That is my job. No man can do it for me. Neither can I do it by myself. So, grant me your prayers, and let me be about doing what I can.

The Social Security Sputnik and Organized Medicine

Recently a poll was taken of the Dade County Medical Association which showed that 56 per cent of our members favored compulsory social security for physicians. As Chairman of their legislative delegation, I am duty bound to make this fact known to all Florida, and if possible, our national councils. It is with a heavy heart and a sense of guilt that I do so. Doctors when presented with sufficient fact have judgment second to none. Few of them, however, have the time to keep informed on matters of economics, and an even smaller number is interested in political methodology. Those of us who are interested, and informed, have a duty to communicate, and this article is an attempt at such communication, in which I have been so remiss.

First and foremost, I feel that compulsion of itself is an evil thing. I have no quarrel with those who want Social Security for themselves, but I do not feel that they should try to force it upon me, any more than they should try to make me drive a Cadillac when I am content to drive a Volkswagen.

I cannot argue successfully that Social Security, if continued as it is presently constituted, would not be financially advantageous for certain of the older age groups. Indeed, it has been the custom to add additional benefits to recipients from time to time without their having to pay for them at all. Our politicians would have us think of a return of $17 for 50 cents as an example of tender loving care. To me, it is simply an example of complete actuarial irresponsibility. Most of us as physicians have paid enough income taxes to finance our senescence in luxury and many times over. Some of the older may try to justify their acceptance of such monies on this ground. I do not believe that even the aged in our profession would want to profit unjustly at the expense of their younger compatriots.

For the younger or middle-aged physician to embrace Social Security willingly is to me unthinkable, because:

1. You are voting for a second Income Tax, and the rates are certain to go up. We were told when the Sixteenth Amendment was passed that Income Tax rates would never exceed 10 per cent. At the present, we are being told similar nonsense about Social Security. Even if no additional benefits were added, Social Security reserves (actually monetized debt) total only 27 billion, while liabilities are already in excess of 247 billion. The only possible source of increased Social Security revenue is an increase in Social Security taxes. Similar benefits in France, for instance, are financed by a 34 per cent payroll tax. Income Taxes have reached the point of diminishing returns. Higher income tax rates simply mean diminished revenue. Social Security will not be financed by Income Tax money because the money simply is not there. Accordingly, cutbacks or increased Social Security taxes will be mandatory.

2. Social Security is welfare legislation pure and simple, and can be changed by the Congress in any way or at any time it sees fit. In case you are one of those who believes in the infallibility of our Supreme Court, a decision was handed down on June 20, 1960, in the case of Fleming vs. Nestor, which certifies to the fact that Social Security is welfare legislation rather than insurance. If the Government itself says Social Security is not insurance, how can others pretend that it is? The Government issues you no policy. You cannot even name your beneficiary. You have to wait 17 months before the plan becomes opera-

tive, and the rather meager stipend which you feel you may possibly draw at some time is *very* stringently qualified. As a matter of fact, you have to swear to live in poverty insofar as professional income is concerned, in order to draw anything at all. I cannot imagine a practicing physician aged 65, with an income of less than $100 a month, if he goes to his office even for one hour a day. Most of us in this day of increased longevity and health enjoy our work far beyond this rather adolescent age limit. Indeed, for the healthy physician really interested in medicine, it is not insurance in any sense of the word. He would never make little enough to draw it.

3. The original Social Security Act provided that you, or your heirs, would be refunded the amount you paid into this fund. This provision has been removed. Social Security needs a transfusion, and the medical profession, I am afraid, has been selected as a donor.

I suppose, however, that if a doctor of 63 intended to retire at age 65 and never set foot in his office again, if this doctor also felt comfortable about passing his burden of retirement on to the younger generation, and if, in addition, he measured all things, even socialism, in strictly economic terms, it is probable he could profit monetarily. Even at this, however, he might *not* profit, in that all the Congress has to do is to pass a law saying simply, "We don't pay," and that is it. A younger man, fearing imminent disability, might also profit if he happened to fit into some particular category, but this type of protection can be obtained elsewhere; again, a "We don't pay" by the Congress is all that is needed to disallow liability.

In summary, it seems fair to say that older physicians would seem to benefit financially from Social Security as it is presently constituted. Younger physicians are simply voting upon themselves a second unlimited income tax in return for benefits which, while specific to a degree at the present time, can nevertheless be changed, altered, amended or eliminated in accordance with the spirit of the times. At least one benefit has already been eliminated; you no longer can get your money back. A far greater danger is that it will be additionally loaded every election year with so many benefits that chaos will ensue. The alternatives to this chaos are either increased Social Security taxes or diminished benefits. Since the law in itself is socialistic in inception, implementation, and action, it takes little perspicacity to see what will happen.

The higher tax rates will be enormously unpopular. Since the additional revenue cannot be obtained by raising income tax rates, there is but one alternative—a cutback in benefits. Where will this cut be made? The labor unions are too potent politically to be treated roughly, but I can see the newspaper headlines even now, "How can the cruel, aggressive, monopolistic and *wealthy* medical profession insist on receiving a meager stipend, which its members do not need, while the poor but noble workers do not have enough to eat?" The amended law itself can be more subtle, "Recipients of Social Security benefits must not receive more than $1,200 per annum from any source." This is all that would be needed. Shall we as physicians join in the present mad rush toward economic cannibalism and the destruction of America, or shall we continue to remain aloof? I say let others have their Social Security. I prefer to run my own life. May God grant that I be allowed to do so.

James L. Anderson, M.D.

University of Florida College of Medicine Announces Seminars

A Category I course on Psychotherapy in Medical Practice for general practitioners is being sponsored by the Florida Academy of General Practice, the Florida Psychiatric Society and the College of Medicine of the University of Florida beginning June 10-11, 1961. This course has been approved by the Florida Medical Association and the Florida State Board of Health. The initial two day program will be presented at the Colony Beach Club Resort, Long Boat Key, Sarasota, and will be followed by 10 weekly group meetings supervised by local psychiatrists. Participants are limited to general practitioners within a 50 mile radius of St. Petersburg.

The faculty for this Seminar is composed of faculty members of the College of Medicine of the University of Florida and the University of Miami School of Medicine, and other members of the Florida Psychiatric Society. They are: Lorant Forizs, M.D., Medical Director, Anclote Manor, Tarpon Springs; Samuel G. Hibbs, M.D., President, Florida Psychiatric Society, Tampa; Alfred D. Koenig, M.D., Clinical Practice of Psychiatry,

St. Petersburg; Joseph J. Regan, M.D., Clinical Practice of Psychiatry, St. Petersburg; Samuel R. Warson, M.D., Chief, Medical Section, Sarasota Memorial Hospital, Sarasota; Paul S. Jarrett, M.D., Clinical Assistant Professor, Department of Psychiatry, University of Miami School of Medicine, Miami; Lindsey D. Campbell, M.D., Clinical Director, Duval Mental Health Clinic, Jacksonville; and Peter F. Regan, III, M.D., Professor and Chairman, Robert S. Glen, M.D., Assistant Professor, and William C. Ruffin Jr., M.D., Instructor, Department of Psychiatry, University of Florida Teaching Hospital, Gainesville.

The Seminar in Neurology, originally scheduled for March 16-18, 1961, will be held on September 28-30 at the College of Medicine of the University of Florida in Gainesville. Demyelinating diseases, pain, epilepsy and other topics of clinical interest will be discussed. This program will be held under the auspices of the Division of Neurology of the Department of Medicine. Among the visiting faculty will be Dr. Augustus S. Rose, Professor of Neurology, University of California at Los Angeles School of Medicine. Those interested in attending the Florida-FSU football game in Gainesville on September 30 should reserve their tickets and hotel accommodations well in advance of this meeting.

Second Medical Seminar Cruise November 2-12, 1961

The second Postgraduate Medical Seminar Cruise through the Caribbean to be conducted by the College of Medicine of the University of Florida has been arranged for November 2-12, 1961. The Seminar will be held aboard the SS Hanseatic, an excellent cruise ship of 30,000 tons. Ports to be visited are Port-au-Prince, Balboa, San Blas, Cartegena, and Kingston, and there will be ample time provided for a visit ashore at each of these ports.

The clinical program will be conducted by faculty members of the College of Medicine and has been planned so as to be of interest and clinical usefulness to practicing physicians. Selected topics in medicine, endocrinology, general surgery, urology, psychiatry, pediatrics, obstetrics and gynecology will be presented.

For further information, write to the Division of Postgraduate Education, College of Medicine, University of Florida, Gainesville.

President Wachtel's Guest At 1961 Annual Meeting



Senator George Smathers of Jacksonville and Miami came to Florida at the early age of four years and was reared in Miami. Upon graduation from the College of Law of the University of Florida in 1938, he entered the private practice of law in Miami. His first public office was that of assistant district attorney. In 1942 he volunteered with the Marine Corps and for 18 months of the four years of his military service he served in the South Pacific. Returning to civil life, he began his higher governmental career by election to the House of Representatives in 1946 and was re-elected two years later. In 1950 he won a seat in the Senate, defeating Claude Pepper by an impressive majority. He was returned to the Senate in 1956 for a second term. For 16 years he has continued to represent the State of Florida with distinction in the Congress of the United States. His current committee assignments include Finance, and Interstate and Foreign Commerce. He is also a member of President Kennedy's Policy Committee.

The address by Senator Smathers will be the feature of the General Session of the Annual Meeting which is scheduled to begin at 11:00 a.m. Friday, May 26.

Medical Assistants Association Holds Annual Meeting Miami Beach, June 2-4, 1961

The Florida Medical Assistants Association attained one of its important goals in September 1960 when a statewide educational program was offered in local colleges and junior colleges under the direction of Dr. Robert L. Fairing of the

Extension Division of the University of Florida in Gainesville. The Board of Governors of the Florida Medical Association, upon recommendation of the Committee on Medical Secretaries and Assistants and the Council on Allied Professions and Vocations, approved three courses for 1960-1961. These are "Psychology of Human Behavior," "Dynamics of Human Behavior," and "Law and Economics in Medical Office Management."

The association will hold its annual meeting June 2-4 at the Seville Hotel in Miami Beach. Mrs. Paula Felan, education chairman, and Mrs. Edith Jones, convention coordinator, have promised the best opportunity to have fun while learning to be better assistants. All medical assistants are invited whether or not they are members of the association.

The General Assembly will be held from 9:00 to 11:00 a.m. on Friday, June 3. Following the business session there will be a panel discussion on "The Health Insurance Council." The participants and their subjects will be: Clifford C. Marshall, Miami, Chairman of the Florida Health Insurance Council, "What Is the Health Insurance Council?"; Burns A. Dobbins, M.D., Fort Lauderdale, President of the Broward County Medical Association and member of the Commercial Health Insurance Committee of the Florida Medical Association. "The Doctor and Health Insurance;" Richard Herman, Miami, Chairman of the Dade County Health Insurance Council, "Simplified Claim Forms;" and Victor E. Hruska, Jacksonville, Chairman of the Medical Relations Committee Health Insurance Committee.

A scientific educational program will be presented on Friday afternoon, covering such subjects as "Key to the Future of Surgery" and "The Heart." Diagnostic laboratory procedures and procedures prior to catheterization and heart surgery will be discussed. "Cardiac Catheterization" is the topic to be discussed by Philip Samet, M.D., Miami Beach, Director, Cardio-Pulmonary Laboratory, Mount Sinai Hospital, Miami Beach, and Robert S. Litwak, M.D., will speak on "Open Heart Surgery."

At the installation banquet on Friday night the featured speaker will be S. Carnes Harvard, M.D., President of the Florida Medical Association. A representative of the American Association of Medical Assistants will also be a guest speaker.

American Medical Association Meets in New York City June 25-30, 1961

The American Medical Association's 110th Annual Meeting, the "world's fair of medicine," will bring an estimated 50,000 persons, including 25,000 physicians, into New York City, June 25-30. The five day convention, biggest of its kind in the world, will attract not only doctors, but also their wives and families as well as residents, interns, exhibitors and people connected with all the allied fields of medicine. The convention theme is "Teamwork in Medicine." The 1961 meeting will mark the eighth time that the American Medical Association has met in New York. The last convention there was in 1957 when 23,888 physicians registered.

Technical exhibits, numbering 827 and displaying everything from medical books to diapers, and more than 350 scientific exhibits largely developed, designed, and manned by physicians reporting their research, will take up practically every inch of space on all four floors of New York's big Coliseum.

The meeting will open formally on Sunday, June 25, with a special preview luncheon and showing in the Coliseum for officers and committee chairmen, members of the Board of Trustees, representatives of the Pharmaceutical Manufacturers' Association, and invited guests. In the past, the conventions opened on Monday, but as a convenience to physicians and in anticipation of the heavy attendance, both the registration facilities and the technical and scientific exhibits will be open and staffed until 5 o'clock Sunday afternoon. Registration hours, Monday through Thursday, will be from 8:30 a.m. to 5:30 p.m., and until 12 noon on Friday, the final day. The Coliseum will be open, however, to physicians only on Tuesday, Wednesday, and Thursday morning.

Dr. Leonard W. Larson, 63 year old pathologist and clinic executive from Bismarck, N. D., will be inaugurated as president of the American Medical Association at 8:30 p.m., Tuesday, in the Waldorf-Astoria ballroom. Dr. Larson, who will give his inaugural address at that time, succeeds Dr. E. Vincent Askey, Los Angeles surgeon. A feature of the inaugural ceremony will be the appearance of the Montgomery County (Ohio) Medical Society Glee Club, which is made up of 45 practicing physicians. A reception and ball for the incoming president will follow the inaugural ceremony.

More than 2,000 physicians will take part in the scientific program, which is designed to keep doctors abreast of what is new in medicine. Teaching mediums will include lectures, symposiums, panel discussions, motion pictures and closed circuit television. More than 300 physicians will deliver lectures before 20 different specialty section meetings. The section meetings, which run simultaneously, will be held not only in the Coliseum, but also in hotels nearby: the Essex House, Barbizon Plaza, the Plaza, Henry Hudson, and Sheraton-Park.

BLUE SHIELD

Plain Talk About Tomorrow

The imminent Congressional battle over President Kennedy's proposal to provide hospital and nursing care for the aged through Social Security poses an obvious and urgent challenge to the medical profession. To put it as simply as possible, medicine is challenged—*now*—to deliver a solid, realistic program of prepaid medical care for the people of the United States through its own voluntary mechanisms, *or* to have such a program organized and imposed upon us by our national government.

To fancy that if we only ignore this threat it will go away is to delude ourselves and to forfeit what may be our last opportunity to preserve private enterprise in medical practice. And it would be incredibly naive to suppose that organized medicine and its business allies can decisively turn back the tide that is running today without offering a clearly preferable substitute program.

What have we to offer? Why not Blue Shield? For, despite the fact that many Blue Shield Plans are inadequate in their scope of coverage and unrealistic in the degree of assurance of complete protection that they offer the patient, nevertheless, Blue Shield has already enlisted the voluntary support of more than a quarter of all the people in the United States.

Blue Shield is the only major prepayment program responsible and responsive to the medical profession, the only major program free of commercial control, the only major program that is creditably identified in the popular mind with the private physician.

Even more important is the fact that Blue Shield has found the formula for providing medical services on terms that have proved eminently satisfactory both to the patient and the doctor. It is safe to say that if all Blue Shield Plans were offering as good a program as the best of them do today, private medicine could meet the challenge of the immediate future with reasonable confidence in the public decision.

Blue Shield can do as good a job as we doctors will *permit* it to do—and it can do as good a job as we *demand* that it do. But in many areas of this land, we physicians must lift the heavy hand of suspicion and restraint from our Blue Shield Plans, and offer these Plans of ours a bold and helping hand of confidence and leadership. There may be other ways of saving free medicine—but Blue Shield lies close at hand—and ready. When do we begin to move?

STATE NEWS ITEMS

Dr. William Y. Sayad of West Palm Beach, Dr. G. Tayloe Gwathmey of Orlando; Drs. Sherman B. Forbes, R. Renfro Duke and Hugh E. Parsons of Tampa, and Drs. W. Jerome Knauer Sr. and William J. Knauer Jr. of Jacksonville attended the recent meeting of the Wilmer Residents Association, Wilmer Ophthalmological Institute of Johns Hopkins Hospital and University held at Baltimore.

Dr. James J. Griffitts of Miami will present two papers at the 107th Annual Session of the Medical Association of Georgia being held in Atlanta. On May 8, he will discuss "Methods of Detecting Antibodies in Serums" at the Pediatrics and Orthopedics Joint Section Meeting, and the following day his topic will be "Transfusion Reactions" for the address at the General Session.

Dr. Eugene L. Jewett of Orlando will present the course on "The Painful Hip" before the Section on Orthopedic Surgery of the North American Federation of the International College of Surgeons' Twenty-Sixth Annual Congress being held in Chicago, May 14-18.

The Section on Ophthalmology and Otolaryngology of the Southern Medical Association is accepting papers for consideration for presentation at the annual meeting of the Association scheduled for Dallas, Texas, November 6-9. The paper or an abstract may be sent directly to the Secre-

tary, Dr. Albert C. Esposito, Suite 1212, First Huntington National Bank Bldg., Huntington, W. Va.

Dr. Jess V. Cohn of Fort Lauderdale was a member of the panel which presented the subject "Crime, Delinquency and the Psychopath" on the program of a joint meeting of the Southern Conference on Corrections and the Florida Psychiatric Treatment of Offenders held at Tallahassee early in March.

Homer F. Marsh, Ph.D., Dean, who has been with the University of Miami School of Medicine since its inception in 1952, has resigned effective June 30 to accept the position as vice president of the University of Tennessee in charge of the medical unit.

Dr. Leon S. Eisenman of Hialeah accepted an invitation to participate in the Eleventh Medical Conference of the Bahamas Conferences in Nassau on April 8.

Dr. Sanford Cobb of Miami attended the recent annual meeting of the Southern Society of Anesthesiologists held at Jackson, Miss., and presented an exhibit from the Department of Anesthesiology of the University of Miami School of Medicine entitled "Pattern for a New Teaching Department."

Drs. Don C. Robertson of Orlando and Harold O. Hallstrand of Miami will serve as participants for the panel discussion of "Cancer of the Colon" before the Section on Colon and Rectal Surgery of the North American Federation of the International College of Surgeons' Twenty-Sixth Annual Congress being held in Chicago, May 14-18.

Dr. Ralph S. Sappenfield of Miami will serve as a General Assembly Participant at the Twenty-Sixth Annual Congress of the North American Federation of the International College of Surgeons being held in Chicago, May 14-18.

Dr. Joseph C. Shipp Jr. of Gainesville, Assistant Professor of Medicine at the University of Florida College of Medicine, has been named a Markle Scholar in Medical Sciences.

Dr. Hyman J. Roberts of West Palm Beach presented an address entitled "Atypical Abdominal Syndromes Due to Systemic Disease" at the recent meeting of the American College of Gastroenterology held in Houston, Texas.

Dr. Jacob A. Glassman of Miami Beach presented an address entitled "The So-Called Simple Hernia" on April 17 during the annual meeting of the American Academy of General Practice held at Miami Beach. Between April 21 and May 2, Dr. Glassman with Dr. Edward H. Rynearson, Professor of Medicine at the Mayo Clinic, presented five surgical and medical addresses at the meeting of the Academy held aboard the SS Franca-C while on a Carribean Cruise.

Dr. Frank G. Slaughter of Jacksonville served as chairman of the Easter Seal Campaign for the greater Jacksonville area.

A grant of $254,500 has been awarded the University of Florida College of Medicine by the U. S. Department of Health, Education, and Welfare to support graduate training in biochemistry. Dr. Frank W. Putnam, Chairman of the Department of Biochemistry, will administer the grant.

Dr. Jacob A. Glassman of Miami Beach will present an exhibit entitled "The Patho-Physiologic Effects of Crushing Intestinal Instruments" at the Mount Sinai Hospital Seminar being held May 18-20 at Miami Beach.

Dr. Nila Kirkpatrick Covalt of Winter Park by invitation attended the meeting of the President's Committee on Employment of the Physically Handicapped in Washington April 27-28.

BIRTHS AND DEATHS

Birth

Dr. and Mrs. Edgar W. Gurganious Jr. of Jacksonville announce the birth of a daughter, Pamela Elizabeth, on February 2, 1961.

Deaths — Members

Andrews, Chadbourne A., Tampa	January	2, 1961
Andrews, Laurin L., Avon Park	February	16, 1961
Brantley, Grady H., Lake Worth	February	9, 1961
Croft, George W., Jacksonville	March	3, 1961
Glenn, Francis W., Coral Gables	February	27, 1961
Kinzie, Joseph L., Lake Wales	February	10, 1961
Mitchell, George A., Coral Gables	March	5, 1961

Deaths — Other Doctors

Cheney, George P., Miami	January	22, 1961
Scott, Sam R., Ocoee	October	22, 1960

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Medical Licenses Granted

Dr. Homer L. Pearson Jr., secretary of the State Board of Medical Examiners, has reported that of the 263 applicants who took the examination of the Board, held November 21-22, 1960, in Miami Beach, 208 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 208 successful applicants follow:

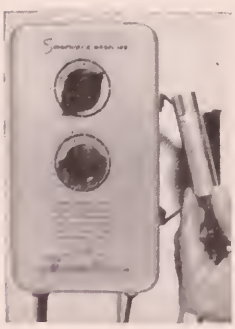
Adams, Paul Lieber, Gainesville (Columbia U. 1955)
Adams, William Curtis, Coral Gables (Temple 1947)
Addington, William Frank, Metairie, La. (U. Virginia 1955)
Adkins, Charles Glen, Durham, N. C. (U. Maryland 1952)
Advocate, Seymour, New York (Washington U. 1950)
Afield, Walter Edward, Atlanta, Ga. (Johns Hopkins U. 1960)
Amatriain, Fernando Fermin, Decatur, Ga. (Emory 1957)
Amdur, Joseph, Miami (U. Rochester 1956)
Andersen, Thorkild W., Gainesville (U. Copenhagen 1947)
Anderson, Axel William III, Orlando (U. Buffalo 1957)
Anderson, Wilbert Richard, Norfolk, Va. (New York Med. Col. 1955)
Angell, Jeanne Ann Fouch, Orrville, Ohio (Duke 1949)
Archibald, Miles Harvey, St. Petersburg (U. Iowa 1960)
Ashkar, Louis Niman, Miami (U. Vermont 1960)
Avellone, Theodore Marcel, Atlanta, Ga. (Western Reserve 1955)
Azzato, Nicholas Michael, Silver Spring, Md. (U. Chicago 1947)
Bader, James Matthew, Gainesville (Western Reserve 1960)

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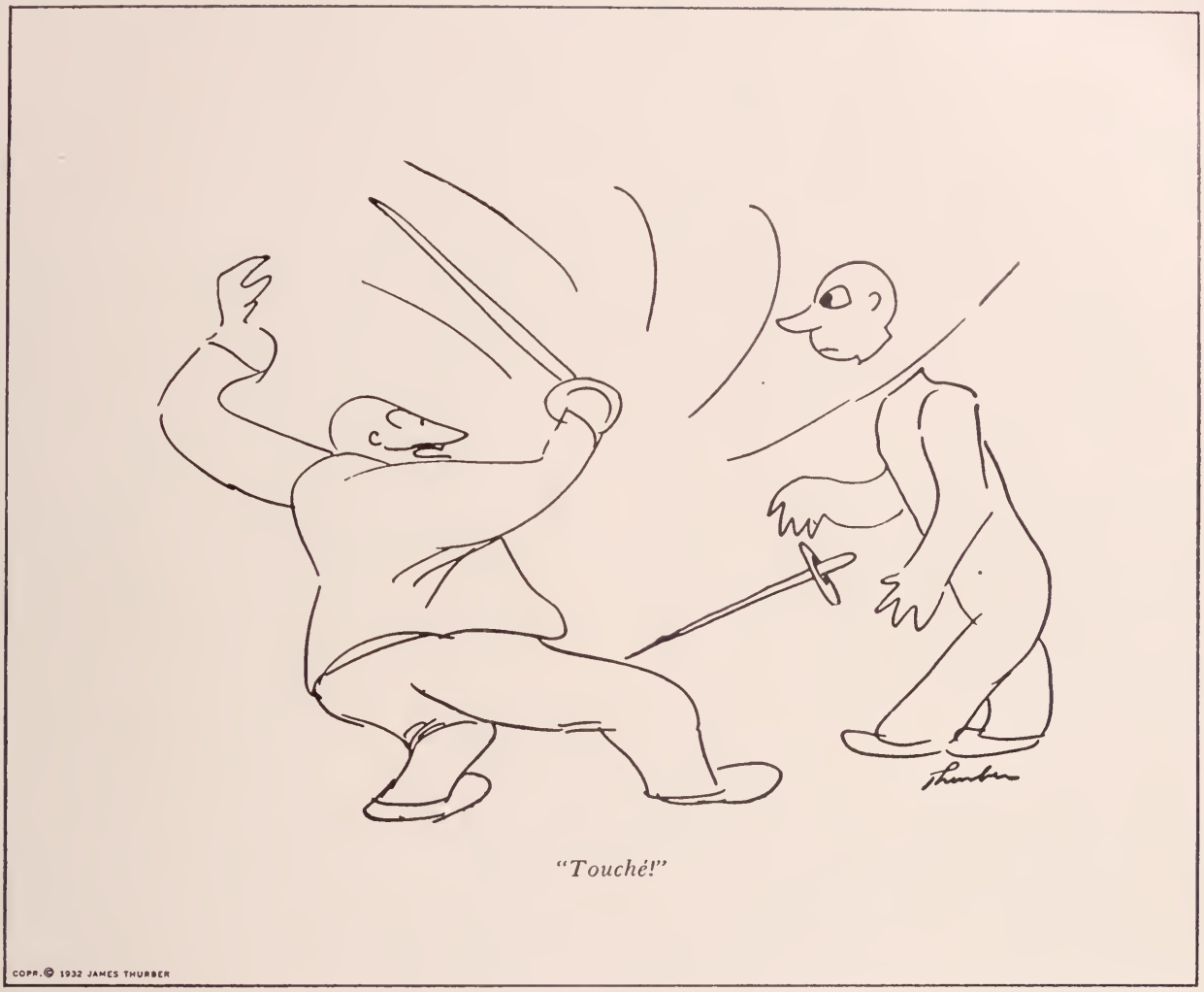
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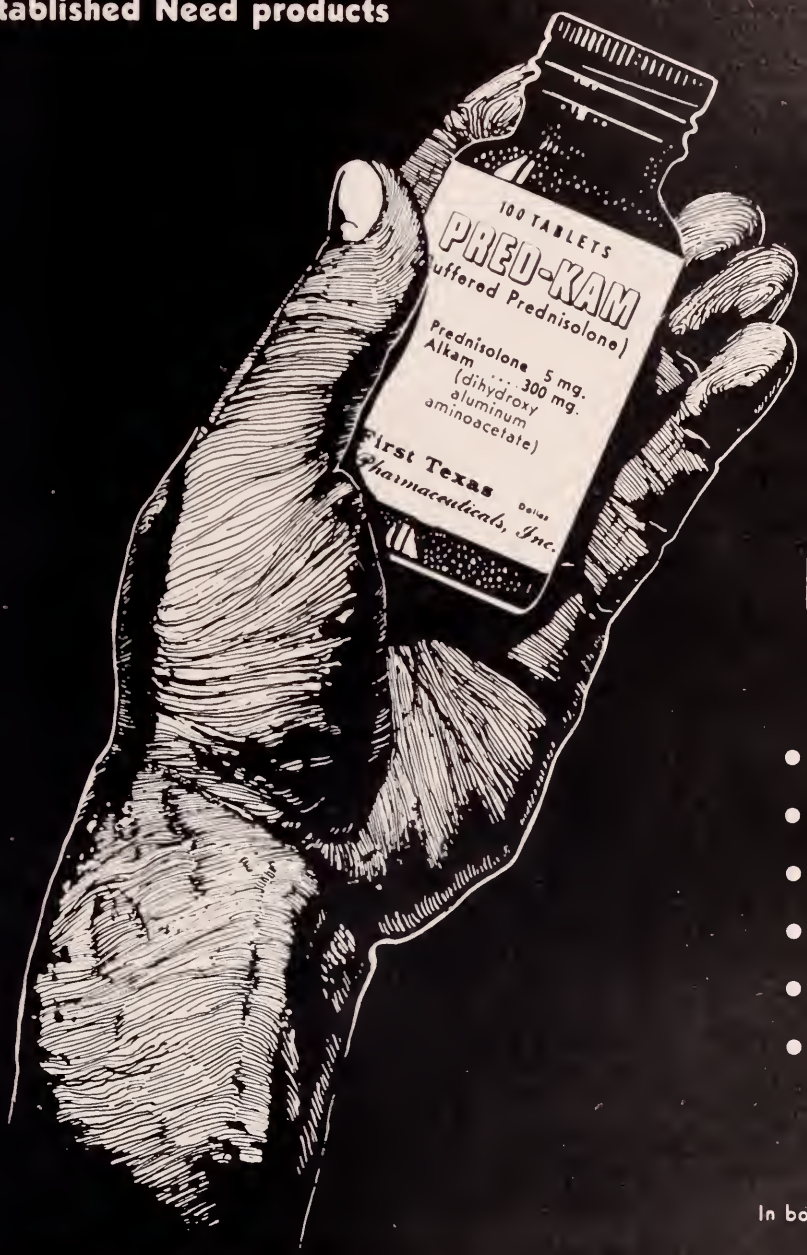
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PDW-12

Balaicuis, Charles William, Miami Beach (Jefferson Med. Col. 1960)
Bartel, Frank Octave Jr., Miami (Med. Col. of South Carolina 1955)
Beckman, Kendall Meredith Jr., Charleston, S. C. (Med. Col. of South Carolina 1959)
Berg, Philip, Levittown, N. Y. (U. Zurich 1957)
Best, Edward Byrd, Gainesville (U. Arkansas 1953)
Blais, Bernard Raymond, Sanford (U. Vermont 1958)
Borland, James Louden Jr., Jacksonville (Johns Hopkins U. 1958)
Brawley, Bob Watson, Gainesville (U. North Carolina 1959)
Brede, Edward Herb III, Miami (U. Miami 1960)
Brodgon, Byron Gilliam, Gainesville (U. Arkansas 1952)
Brown, Carleton Justus, Jacksonville (Yale 1945)
Buckley, Charles Edward III, Durham, N. C. (Duke 1954)
Buckley, Rebecca Hatcher, Durham, N. C. (U. North Carolina 1958)
Burney, Robert Earle II, Fort Lewis, Wash. (U. Miami 1960)
Byrnes, Victor Allen, St. Petersburg (U. Texas 1929)
Byrum, Fritz Arnold, Tampa (U. Mississippi 1959)
Carmichael, Grant Perry, Macon, Ga. (Med. Col. Georgia 1960)
Caspersen, John Westby, Venice (Temple 1959)
Catalano, Ottavio Philip Martin, Tampa (U. Pennsylvania 1960)
Collier, Fred Clark, Tampa (Yale 1946)
Creighton, Francis Sylvester, Fort Lauderdale (Georgetown Med. School 1930)
Crist, Charles Joseph, St. Petersburg (Emory 1960)
Crymes, James Elbert III, Atlanta (Duke 1960)
Cuthbert, Richard Bruce Jr., Clearwater (Syracuse U. 1929)
Davis, Jordan Kent, Miami (Med. Col. Alabama 1960)
Dickey, Morris William, St. Petersburg (Indiana U. 1952)
Drlicka, Albert Vojtech, Pensacola (U. Paris 1954)
Duggan, Charles Anderson Jr., Norfolk, Va. (Emory 1958)
Dunlap, Donald Robert, Miami (Indiana U. 1960)
Edwards, George Thomas, Miami (Northwestern 1955)
Ellis, David Melech, Miami Beach (Temple 1960)
Ellis, Elliot Frederic, Eglin AFB (Western Reserve 1954)
Enyart, John Leslie, Jacksonville (Northwestern 1927)
Epstein, Lester, Miami (U. Munich 1959)
Eschenburg, Charles Grant, Denver (U. Colorado 1955)
Evans, John Thomas Jr., Augusta, Ga. (Ohio State U. 1956)
Facundus, Jack Pevey, Monroe, La. (Col. Med. Evangelists 1959)
Farrow, Cyrus Creston Jr., Norfolk, Va. (U. Virginia 1951)
Felder, Michael, Fort Lauderdale (State U. of New York 1955)
Feltman, Robert Ferree, Miami (George Washington U. 1952)
Ferguson, Thomas Bruce, Tampa (Duke 1947)
Fisher, Luther Calvin III, Pensacola (Tulane 1960)
Fleischaker, Jerry Jerome, Durham, N. C. (U. Louisville 1955)
Fleisher, Harvey Allen, Laurelton, L. I., N. Y. (U. Munich 1959)
Flynn, James Michael, Jacksonville (U. Iowa 1960)
Folger, Gordon Merrill Jr., Mount Dora (Tulane 1956)
Ford, J. Clark, Beaufort, S. C. (Louisiana State U. 1955)
Foster, Augutus Hunter Jr., Columbia, S. C. (Col. Med. Evangelists 1951)
Foyt, John Vernon, Miami (Hahnemann Med. Col. 1956)
Frankel, Toby, Brooklyn (Chicago Med. School 1959)
Fraser, Donald James, Woodbury, N. J. (Hahnemann Med. Col. 1956)
Freedman, Howard H., Philadelphia (Jefferson Med. Col. 1959)
Gamble, James Edward, Miami (U. Louisville 1960)
Gamse, Norman Leo, Laredo, Tex. (Johns Hopkins U. 1959)
Garcia, David Enrique, Miami (Duke 1958)
Gleason, William Lounsbery, Rockville, Md. (Duke 1953)

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Green, James Russell Jr., Gainesville (U. Virginia 1955)
Greenberg, Jonathan Benjamin, Boston (U. Zurich 1956)
Greenfield, George B., Chicago (U. Utrecht 1956)
Guzzetta, Philip Conte, Milwaukee (Marquette 1939)
Hagen, John Stewart III, Miami (U. Cincinnati 1960)
Hayes, Richard Read, Jacksonville (Tulane 1958)
Harper, Fleming Bates, St. Louis (Med. Col. Virginia 1947)
Hazinski, Robert Theodore, Gary, Ind. (Loyola 1940)
Hendricks, Charles Mack (Col.), West Palm Beach (Meharry 1956)
Henkin, Irwin Robert, Miami (U. California 1959)
Henry, John Bernard, Gainesville (U. Rochester 1955)
Hilf, Paul Burton, Chicago (Tulane 1959)
Hodge, Maurice, Miami (U. Tennessee 1959)
Hoskins, Phillip Alfred, Miami (Indiana U. 1960)
Irvine, Donald William, Tampa (U. Tennessee 1959)
Jacobson, Lawrence Harold, Eau Gallie (New York U. 1957)
James, Charles Clarence Jr., Coral Gables (U. Miami 1960)
Jannach, Joseph Robert, Miami (U. Minnesota 1954)
Johnson, Andrew Myron, Boston (Vanderbilt 1959)
Johnson, Stanley Emerson (Col.), Kansas City, Kans. (Meharry 1956)
Jones, Paul Kendrick, Key West (Albany Med. Col. 1955)
Kalser, Martin Howard, Miami (U. Pittsburgh 1946)
Karam, Farid, Cleveland (American U. of Beirut 1954)
Kass, Donald Martin, Miami Beach (Lausanne 1956)
Kline, Stanley Ronald, Ventnor City, N. J. (Hahnemann Med. Col. 1955)
Kloiparens, James Thomas, Minneapolis (U. Michigan 1955)
Kollar, Charles Stephen, Valdosta, Ga. (Georgetown U. 1941)
Kruggel, John Louis, Dover, Dela. (U. Iowa 1957)
Landstra, Robert Frank, Lubbock, Tex. (U. Michigan 1950)
Lane, Paul Jon, Norristown, Pa. (Jefferson Med. Col. 1948)
Lavietes, Paul Alan, Atlanta (Med. Col. Georgia 1955)
Lescher, Charles Frederick, Atlanta, Ga. (Marquette 1955)
Lipsey, John Crawford, Greenville, S. C. (Tulane 1956)
Little, Wilfred Duffield Jr., Tampa (U. North Carolina 1959)
Long, Richard Norton Jr., Tampa (U. Missouri 1959)
Lore, Charles Eli, Gainesville (U. North Carolina 1960)
Lovett, Warren Clay, Jacksonville (Col. Med. Evangelists 1959)
Lowe, Charles Edward, Gainesville (U. Buffalo 1957)
McAllister, James Gray III, Jacksonville (U. North Carolina 1960)
McMeel, John Wallace, Boston (George Washington, U. 1953)
Mahoney, William Francis, Dearborn, Mich. (U. Michigan 1957)
Manthey, Charles Edwin, Fort Lauderdale (George Washington U. 1946)
Marsh, Bernard Royal, Baltimore (Col. Med. Evangelists 1959)
Marsteller, Daryl Hoover, Beaufort, S. C. (Hahnemann Med. Col. 1956)
Marvin, Lawrence Leslie, Fort Worth, Tex. (Col. Med. Evangelists 1959)
Matta, Enrique Leon Jr., Tallahassee (Jefferson Med. Col. 1940)
Mayer, Lloyd Dewald, Lexington, Ky. (U. Louisville 1944)
Mayo, Marvin Glen, Orlando (Washington U. 1960)
Mazza, Joseph Louis, Pittsburgh (U. Pittsburgh 1951)
Menigatti, Diego Manlio, Miami (U. Rome 1953)
Middleton, Paul, Orlando (Med. Col. Virginia 1955)
Minovitch, Eva Sima, Miami (U. Geneva 1957)
Moore, Charles Leslie, Winston-Salem, N. C. (Bowman Gray 1954)

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1. Clein, N. W.: Pediat. Clin. North America, Nov., 1954, pp. 949-962.

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Morley, Shirley Ann, Sarasota (Columbia U. 1956)
Morrell, Roger Merritt, Fort Lauderdale (George Washington U. 1954)
Musselman, Glen Paul, Bartow (Temple 1954)
Nevis, Arnold Hastings, Gainesville (Harvard 1951)
Newman, Leo Sigmund, Fort Lauderdale (U. Cincinnati 1960)
Noble, Charles Raymond, Orlando (U. Louisville 1960)
Okano, Takeshi, Largo (Tulane 1947)
Olson, Robert Wayne, Hampton, Va. (Northwestern 1960)
Panaro, Robert John, Travis AFB, Calif. (U. Ghent 1957)
Parker, Lemoine Burton, Indianapolis (Col. Med. Evangelists 1949)
Payne, Philip Marshall II, Gainesville (U. Virginia 1960)
Peare, Reeve Burton, Tampa (Indiana U. 1960)
Pepper, Marshall Alan, Miami (Jefferson Med. Col. 1959)
Peterson, Arthur Riley, Coral Gables (McGill U. 1957)
Pinosky, David Gordan, Miami (Med. Col. of South Carolina 1959)
Prather, Elbert Charlton, Jacksonville (Bowman Gray 1959)
Quigley, Nelson Joseph, Tampa (Temple 1960)
Riggins, Richard Stafford, Lake Worth (Duke 1960)
Rodgers, John David, Warrensville, Ohio (U. Pittsburgh 1950)
Rodriguez, Josefina Carmen Hortensia, Perry Point, Md. (Santo Domingo U. 1952)
Rogers, Arvey I., Miami (U. Texas 1958)
Roop, Walter Earl, Gainesville (U. Miami 1959)
Rushton, Francis Edwards, Gainesville (U. Virginia 1957)
Sandella, Joseph Frank, New Brunswick, N. J. (U. Med. School & Bellevue Hosp. 1931)
Saporito, Charles Joseph, Tarpon Springs (Louisiana State U. 1957)
Schen, Charles Richardson, Blasdell, N. Y. (State U. of New York 1955)
Scherr, Ronald Herbert, Tampa (Temple 1960)
Schiebler, Gerald Ludwig, Gainesville (Harvard 1954)
Schine, Lawrence Charles, Miami (U. Vermont 1960)
Schlecker, Abraham, Miami (U. Med. School & Bellevue Hosp. 1924)
Schultz, Marvin Harold, Marquette, Mich. (U. Iowa 1946)
Schwalb, Eugene, San Antonio, Tex. (U. Basel 1958)
Segal, Samuel Jerome, Fort Benning, Ga. (Med. Col. of South Carolina 1958)
Sellyei, Louis Francis Jr., St. Petersburg (Hahnemann Med. Col. 1960)
Seyfert, John Jr., Miami (Emory 1959)
Shaw, Walter Morgan, Miami (U. Maryland 1957)
Shedden, William Martindale, Ormond Beach (Harvard 1920)
Shipp, Joseph Calvin, Gainesville (Columbia U. 1952)
Shuttleworth, John George, Birmingham, Ala. (Med. Col. Alabama 1957)
Silver, Richard Arnold, Indianapolis (Indiana U. 1944)
Simmons, Roy Paul, Miami (New York U. 1955)
Sloss, Joseph Henry, St. Petersburg (Jefferson Med. Col. 1952)
Smith, Donald Dewey, Gainesville (Duke 1960)
Smitherman, Frank Byron, Perrine (Bowman Gray 1956)
Sokol, Donald Z., Fort Lauderdale (Tufts 1960)
Sparer, William, New York (New York U. 1929)
Sprenger, Thomas Robert, Tampa (Indiana U. 1956)
Steiner, Leonard Edward, Corpus Christi (U. Wisconsin 1956)
Stobaugh, Robert Edward, St. Petersburg (U. Oklahoma 1960)
Straumfjord, Jon Vidalin Jr., Miami (U. Oregon 1953)
Stump, Charles Albert, Gainesville (George Washington U. 1952)
Suarez, Jose Raul, Tampa (Madrid Med. School 1958)
Suggs, Thelbert Rudolph, Crescent City (Med. Col. of South Carolina 1959)



Sutton, Harold Samuel, Orlando (U. Tennessee 1959)
Sweeny, John Paul, Valley Stream, N. Y. (New York U. 1956)
Talbot, Sterrett Tom, Miami (U. Cincinnati 1960)
Tanner, Maurice Baskerville, St. Petersburg (Med. Col. Virginia 1960)
Tardy, Medney Eugene Jr., Tampa (Indiana U. 1960)
Taylor, David Lebo, Miami (Bowman Gray 1955)
Taylor, William John Jr., Miami (Washington U. 1959)
Thomas, Robert Lee Jr., Jacksonville (Med. Col. Alabama 1954)
Tucker, Daniel Noe Jr., Gainesville (Duke 1958)
Verdon, Robert Edward, Cliffside Park, N. J. (St. Louis U. 1938)
Vinik, Melvin, Miami (U. Chicago 1960)
von Ruckteschell, Arno, Warren, Pa. (Christian Albrechts U. 1952)
Walch, Francis Robert, Winchester, Va. (U. Pittsburgh 1947)
Walker, Levi Moore, Atlantic City (U. Pittsburgh 1926)
Walton, Joseph Albert Jr., Gainesville (U. Florida 1960)
Wansley, Billy Morris, Miami (U. Mississippi 1960)
Ward, Walter Elliott, Robersonville, N. C. (Med. Col. Virginia 1940)
Weiss, Gary Allen, Miami Beach (Temple 1960)
Wendel, Alvin Paul, Coral Gables (U. Illinois 1952)
Wiener, Stanley Morton, Gainesville (U. Amsterdam 1958)
Willey, Ronald Raymond, St. Petersburg (U. Pittsburgh 1959)
Wilson, Peter George, New York (Columbia U. 1957)
Winner, William, North Miami Beach (Columbia U. 1956)
Yeager, Otis Wayne, Jacksonville (Emory 1939)
Zahler, Sanford Fischel, Miami (Med. Col. of South Carolina 1956)
Zmyslowski, Walter Peter, Worcester, Mass. (Tufts 1956)

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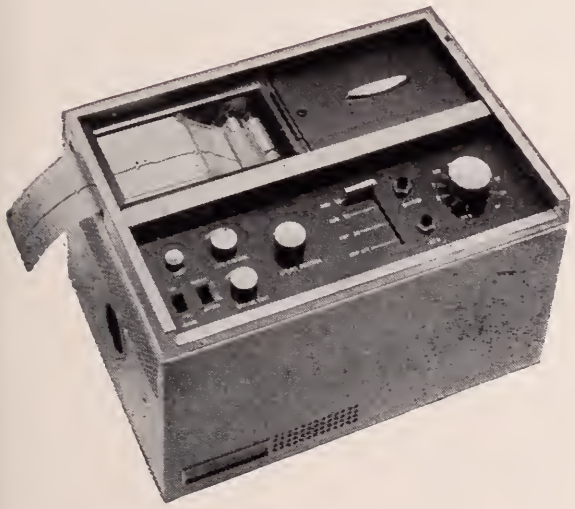
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References: 1. Freedman, A. M.: Pediat. Clin. North America *5*:573 (Aug.) 1958. 2. Nathan, L. A., and Andelman, M. B.: Illinois M. J. *112*:171 (Oct.) 1957. 3. Santos, I. M. H., and Unger, L.: Ann. Allergy *18*:179 (Feb.) 1960. 4. Litchfield. H. R.: New York J. Med. *60*:518 (Feb. 15) 1960.

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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

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arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L.: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition. National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition. J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . .There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan, G. G.: Diseases of Metabolism, 4th edition. W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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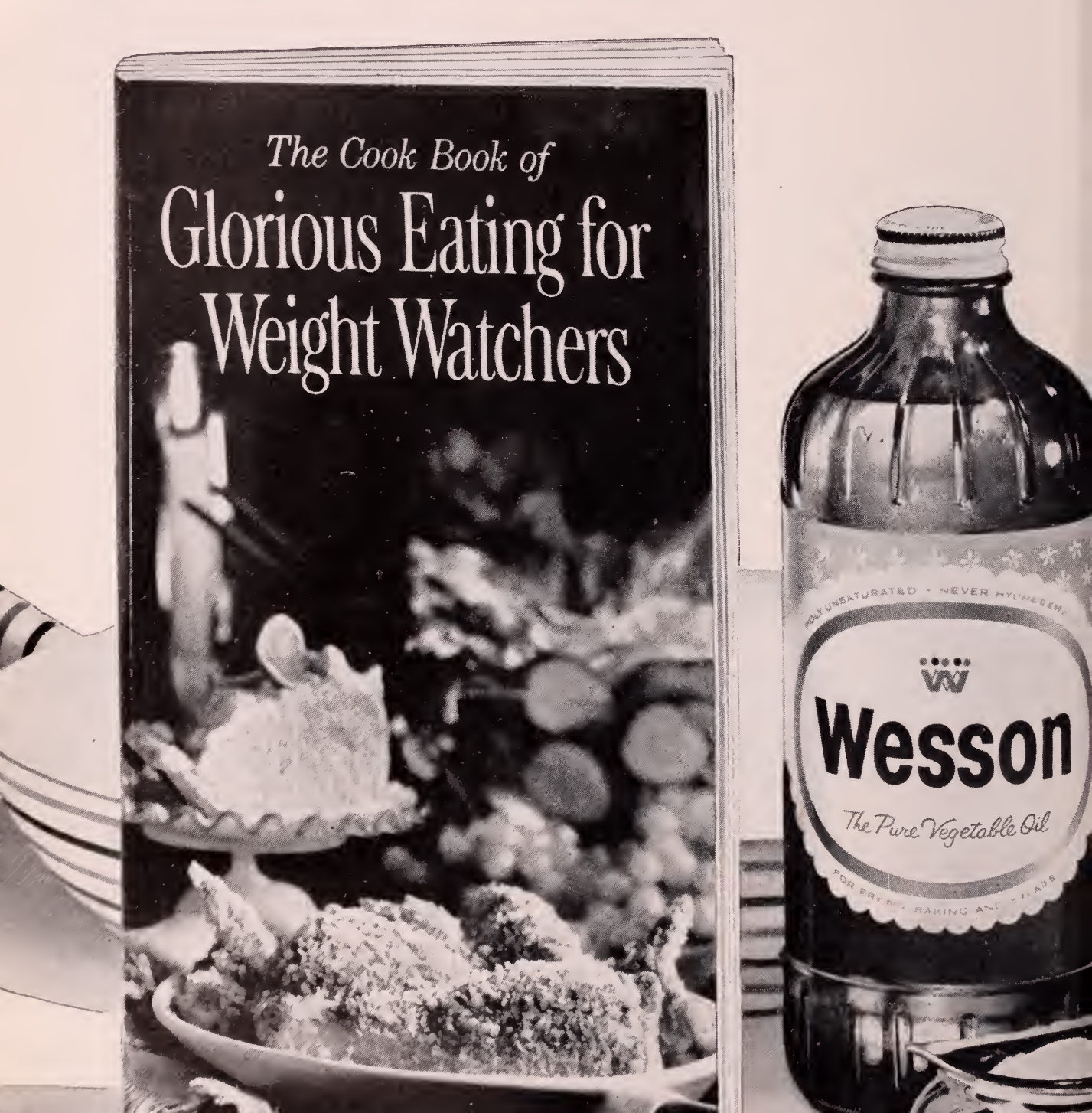
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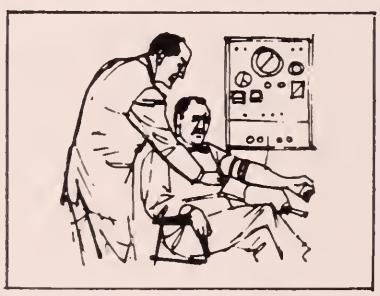
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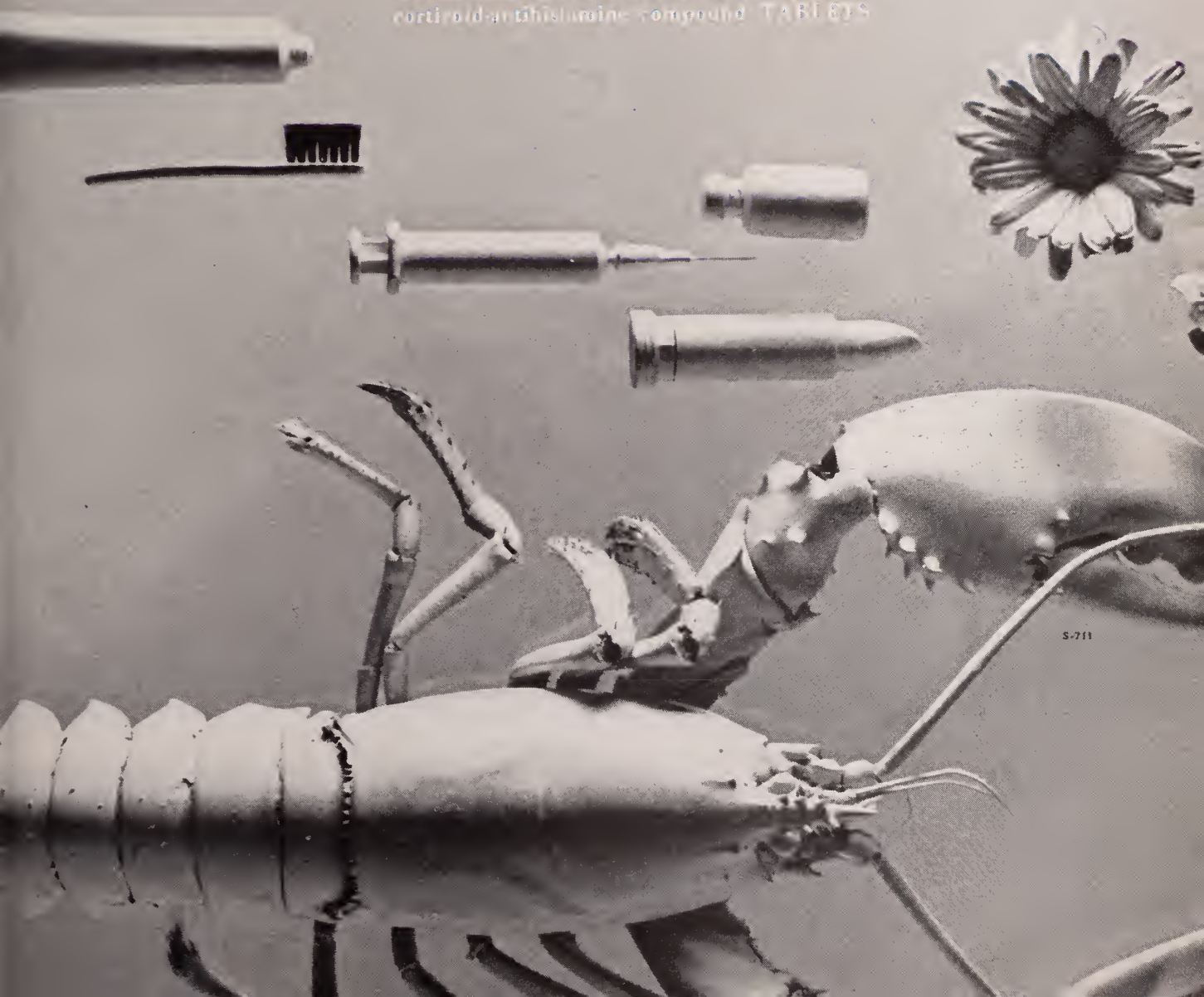
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> Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days. (J.A. M.A. Vol. 172, No. 18, April 30, 1960.)*

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE:** 1 TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

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Rautrax-N lowers high blood pressure gently, gradually . . . protects against sharp fluctuations in the normal pressure swing.

Rautrax-N offers all the advantages of Raudixin, Naturetin and potassium chloride in a single dosage form *plus: increased efficacy* – Combined action of Raudixin and Naturetin results in a potentiated antihypertensive effect greater than that produced by either drug alone. *increased safety* – Potentiated action permits lower dose of other antihypertensive agents, thus reducing severity of side effects. Protection against possible potassium depletion. *flexibility* – Interchangeable with either Raudixin or Naturetin c K. *economy* – Maintenance dosage of only 1 or 2 tablets daily for most patients. *convenience* – Once-a-day maintenance dosage. Two potencies available.

Supply: Rautrax-N – capsule-shaped tablets providing 50 mg. Raudixin, 4 mg. Naturetin and 400 mg. potassium chloride. *Rautrax-N Modified* – capsule-shaped tablets providing 50 mg. Raudixin, 2 mg. Naturetin and 400 mg. potassium chloride.

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Squibb Standardized Whole Root Rauwolfia Serpentina (Raudixin) and Bendroflumethiazide (*Naturetin) with Potassium Chloride

For full information, see your Squibb Product Reference or Product Brief.

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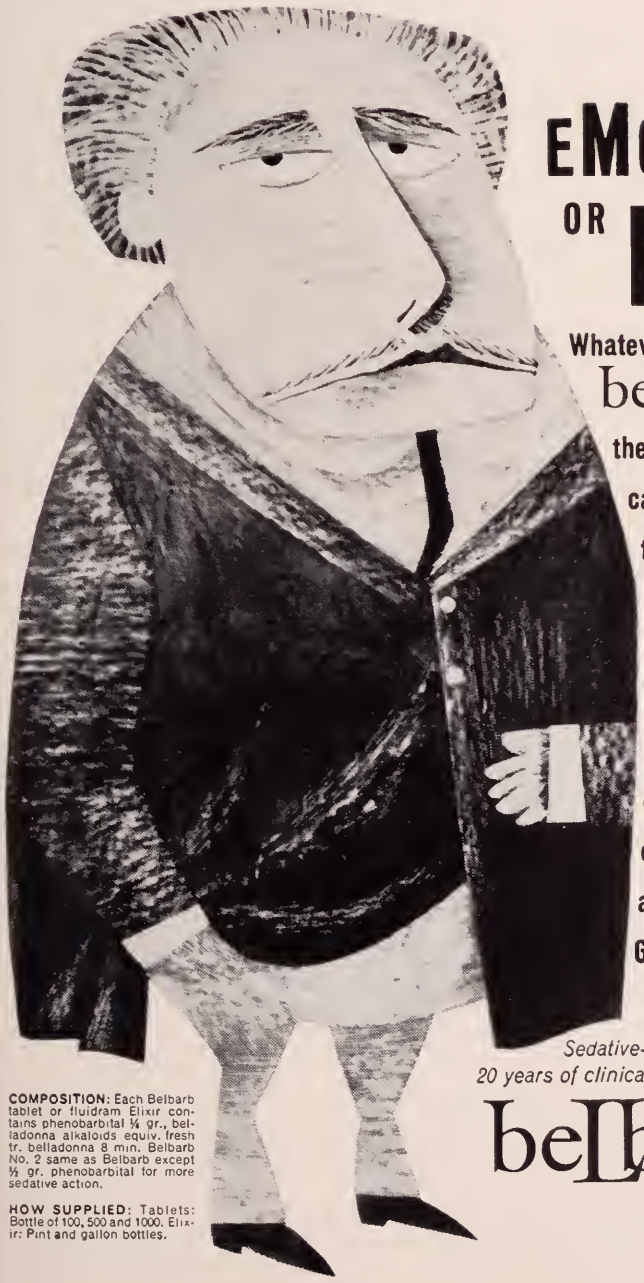
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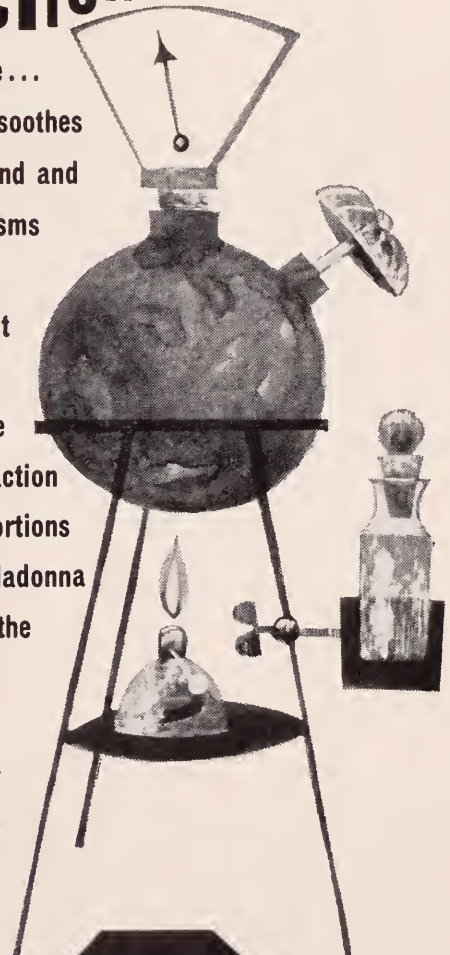
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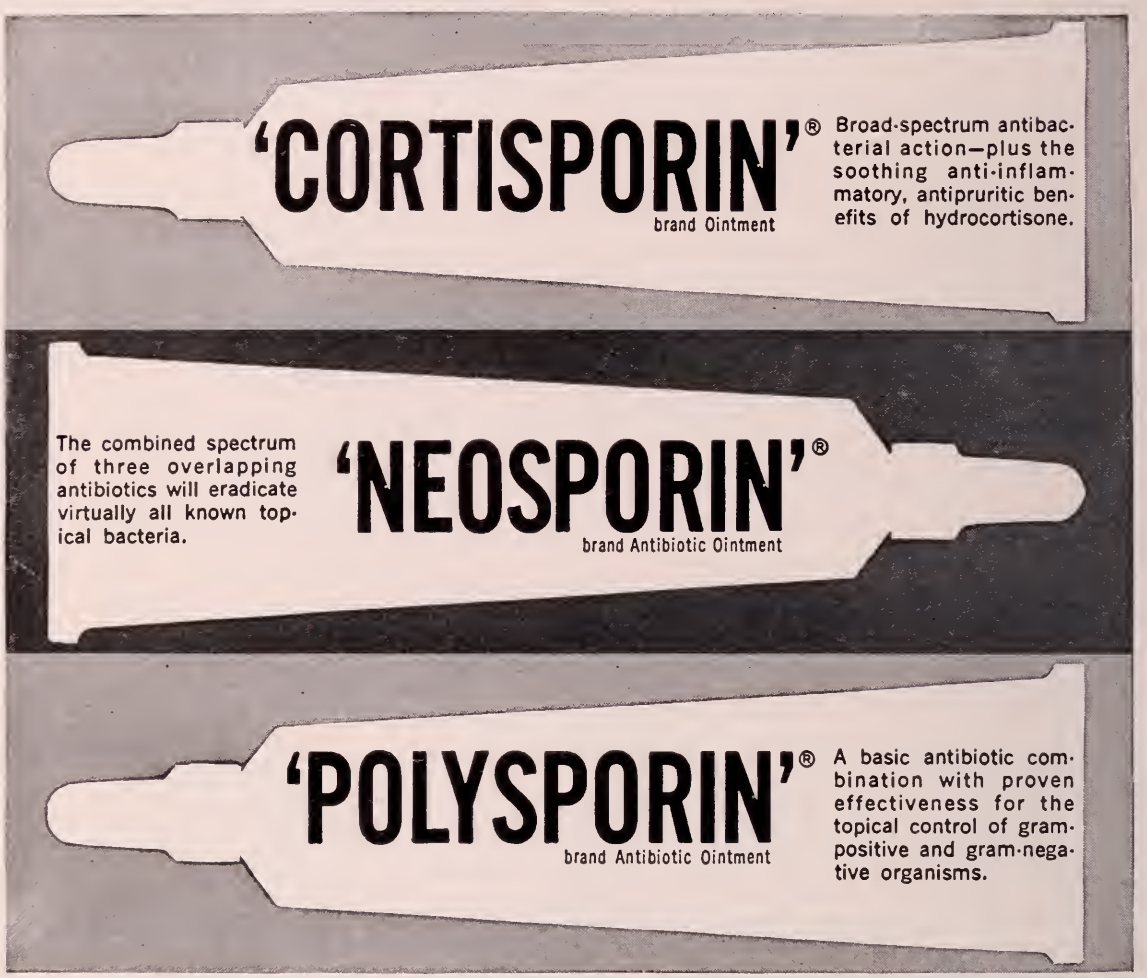
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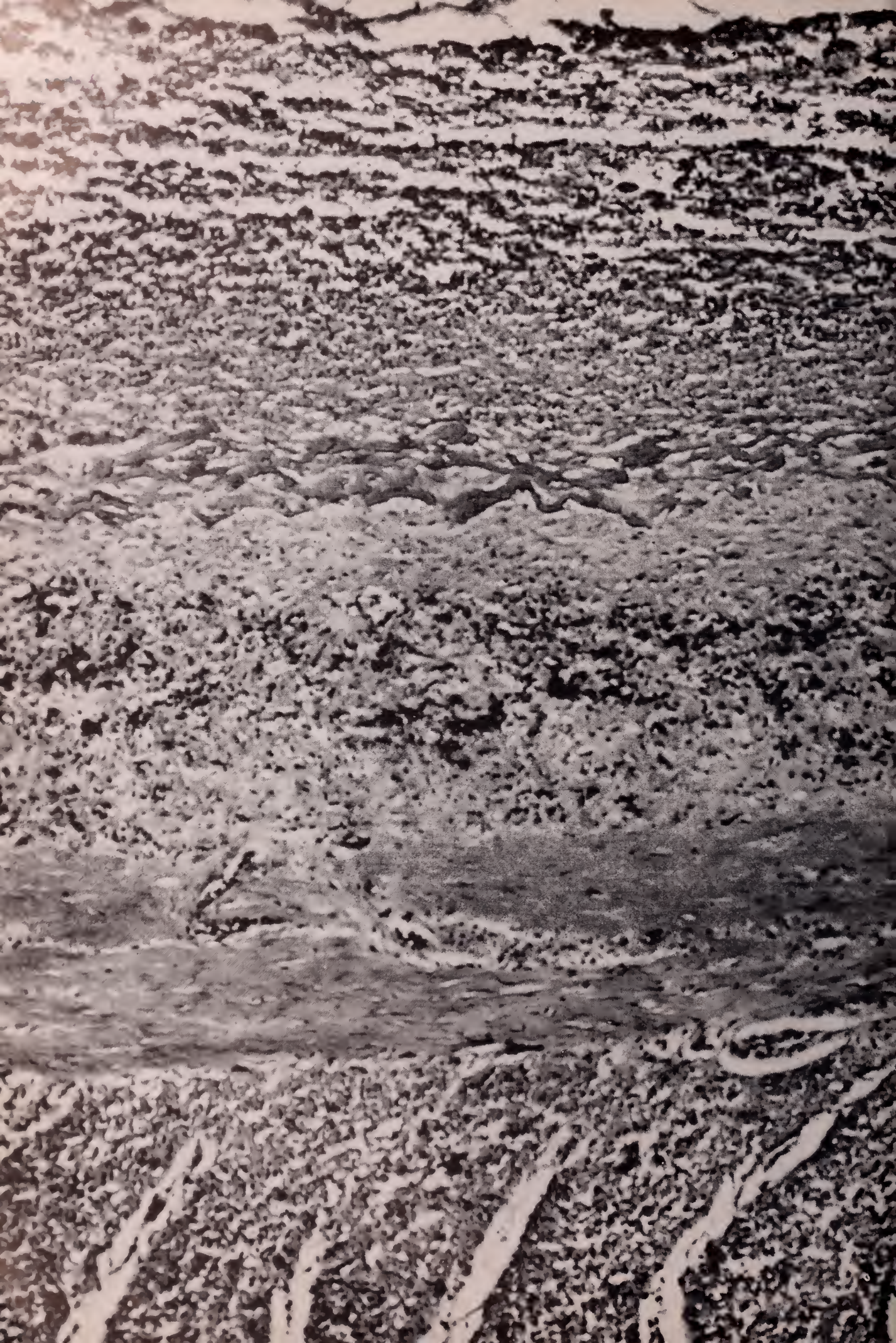
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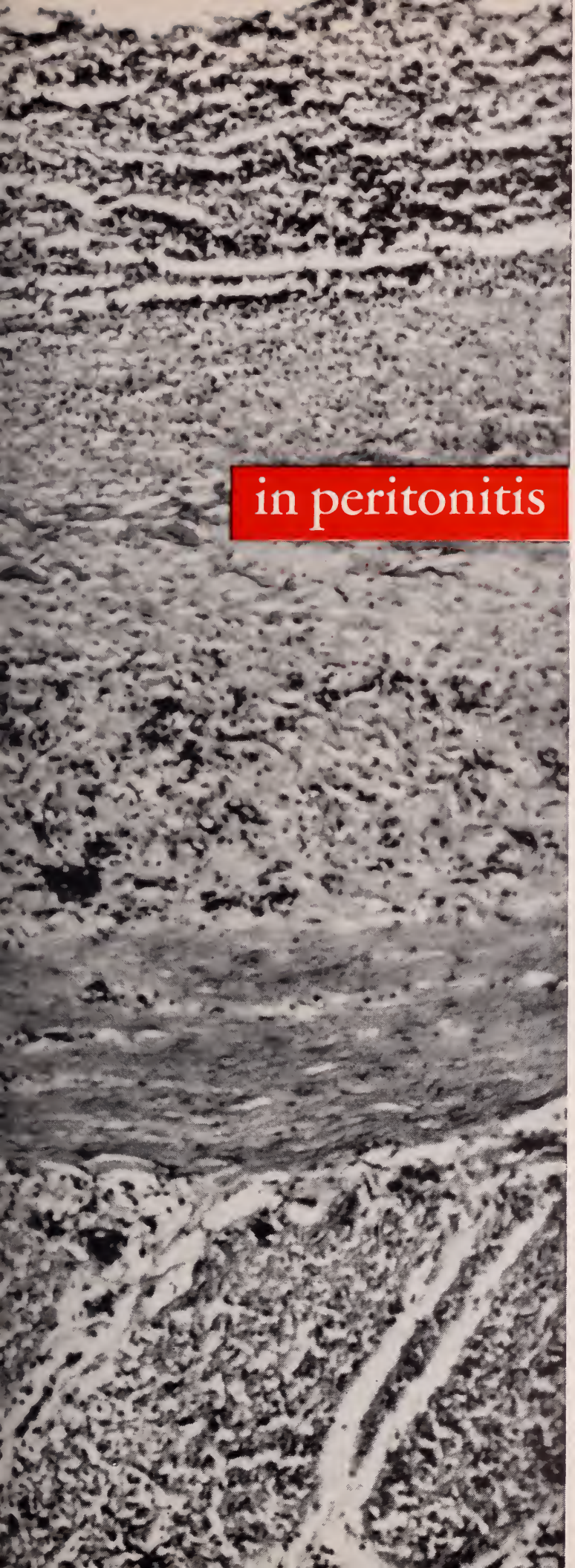
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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.





in peritonitis

Therapeutic confidence

Panalba is effective against more than 30 commonly encountered pathogens including ubiquitous staphylococci. Right from the start, prescribing it gives you a high degree of assurance of obtaining the desired anti-infective action in this as in a wide variety of bacterial diseases.

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

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Side effects: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use in patients are infrequent and consist principally of mild nausea and abdominal cramps.

Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests.

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As with any serious infection, therapy of peritonitis with Panalba or other antibacterial agents is adjunctive to surgical procedures and supportive therapy.

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Percodan tablets effectively relieve pain through a range of



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prompt relief
profound relief
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ACTS FASTER—usually within 5-15 minutes. LASTS LONGER—usually 6 hours or more. MORE THOROUGH RELIEF—permits uninterrupted sleep through the night. RARELY CONSTIPATES—excellent for chronic or bedridden patients.

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Also available—for greater flexibility in dosage—PERCODAN®-DEMI: The PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

LITERATURE AVAILABLE ON REQUEST

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*U.S. Patent Nos. 2,628,185 and 2,907,768

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STUDY 1 *Spoor, H. J.: N. Y. State J.M. 58:3292, 1958.*

satisfactory results in 88% of cases

comments: "In practically every instance... the patients experienced relief from dryness and pruritus."

STUDY 2 *Lubowe, I. I.: Western Med. 1:45, 1960.*

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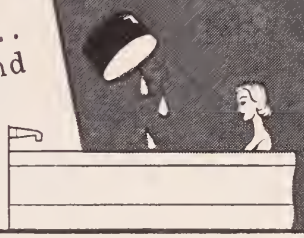
STUDY 3 *Weissberg, G.: Clin. Med. 7:1161, 1960.*

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comments: "Scaling disappeared, and... the skin became softer and smoother..." with Sardo.

INDICATIONS

eczematoid dermatitis
atopic dermatitis
senile pruritus
contact dermatitis
nummular dermatitis
neurodermatitis
soap dermatitis
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SARDO IN THE BATH releases millions of microfine water-miscible globules* which act to (a) lubricate and soften skin, (b) replenish natural emollient oil, (c) prevent excessive evaporation of essential moisture.

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Non-sticky, non-sensitizing, economical. Bottles of 4, 8 and 16 oz.

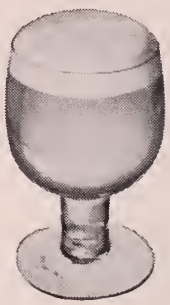


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How to help your patients stick to a high vitamin-mineral diet

The secret ingredient in a successful diet is acceptance. If foods are varied and inviting, a patient will follow the diet more faithfully. An attractive source of calcium, iron, Vitamin A, B_2, niacin and C is this cottage cheese salad dotted with dried fruits and peanuts. Oysters supply vitamins A and D, iron and calcium. Colorful cabbage-carrot slaw contains vitamins A and C, and calcium. For dessert: custard topped with orange juice concentrate, providing calcium, plus vitamins A, B_1, B_2 and C.



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8 oz. glass contains 10 mg. calcium, 50 mg phosphorus, ⅛ min. daily requirement of niacin, smaller amounts of other B-complex vitamins. (Average of American Beers)



Patients show no lack of enthusiasm for appetizing diet dishes.

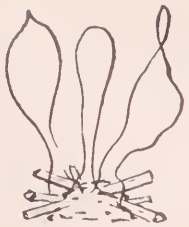
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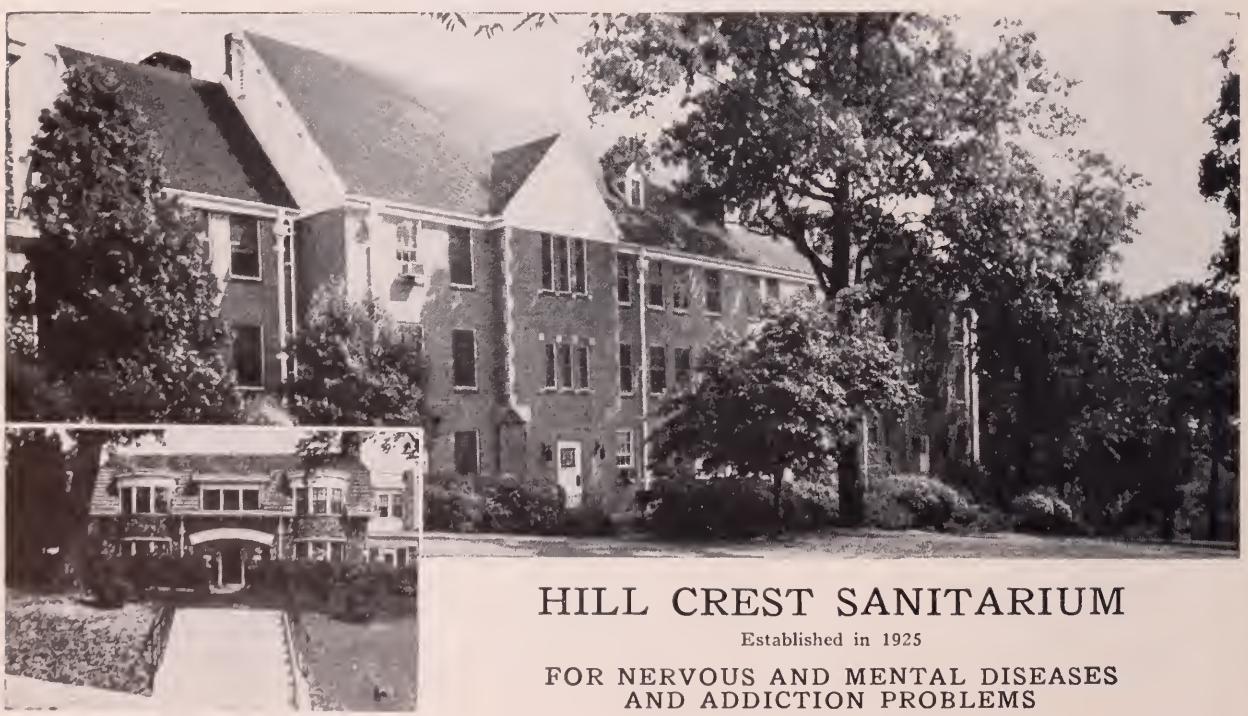


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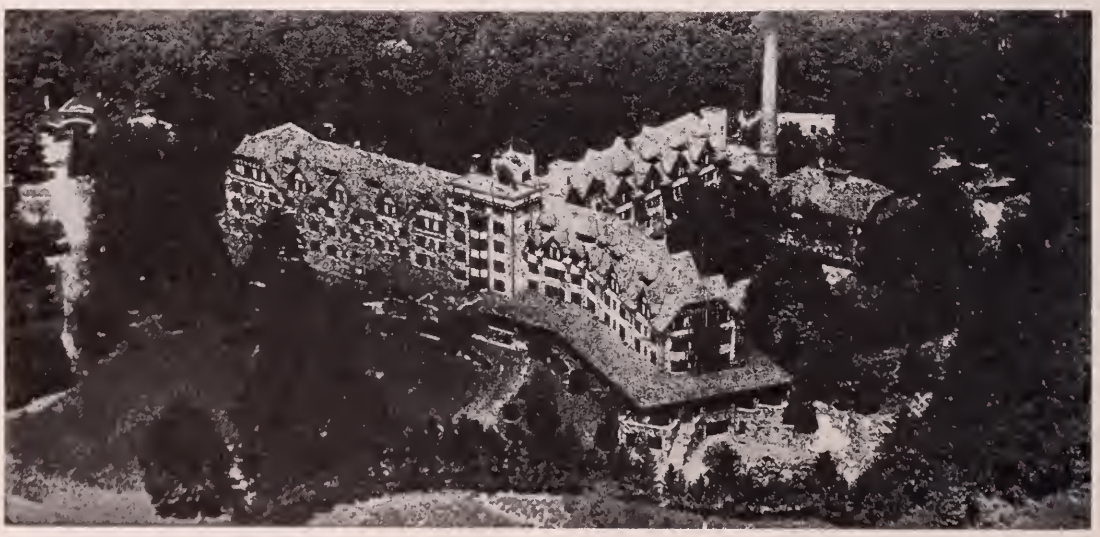
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Florida Specialty Societies			
Academy of General Practice	Willard E. Manry Jr., Lake Wales	A. MacKenzie Manson, Jacks'ville	Miami Beach, May 27-28, '61
Allergy Society	I. Irving Weintraub, Gainesville	Ben A. Johnson Jr., Jacksonville	Miami Beach, May 27-28, '61
Anesthesiologists, Soc. of	Richard S. Hodes, Tampa	J. Thomas Atkins, Jacksonville	" " " " " "
Chest. Phys. Am. Coll., Fla. Chap.	Ivan C. Schmidt., W. Palm Beach	Harold W. Johnston, Orlando	Miami Beach, May 27, '61
Dermatology, Soc. of	Jack H. Bowen, Jacksonville	William C. Croom Jr., Jacksonville	" " " " "
Health Officers' Society	J. Basil Hall, Tavares	James O. Bond, Jacksonville	Miami Beach, May 28, '61
Industrial and Railway Surgeons	Fred H. Albee Jr., Daytona Beach	John H. Mitchell, Jacksonville	Miami Beach, May 27, '61
Internal Medicine	William C. Blake, Tampa	Charles K. Donegan, St. Petersburg	Miami Beach, May 28, '61
Neurosurgical Society	Irwin Perlmutter, Coral Gables	David H. Reynolds, Miami	" " " " "
Ob. and Gynec. Society	T. Bert Fletcher Jr., Tallahassee	Sam W. Denham, Jacksonville	" " " " "
Ophthal. & Otol., Soc. of	Kenneth S. Whitmer, Miami	Joseph W. Taylor Jr., Tampa	Miami Beach, May 27, '61
Orthopedic Society	Michael DiCosola, Sarasota	Theodore Norley, W. Palm Beach	" " " " "
Pathologists, Society of	John B. Miale, Miami	John A. Shively, Bradenton	" " " " "
Pediatric Society	J. K. David Jr., Jacksonville	John H. Cordes Jr., St. Petersburg	Miami Beach, May 27-28, '61
Plastic & Reconstructive Surgery	Joseph E. O'Malley, Orlando	John M. Hamilton, St. Petersburg	" " " " " "
Proctologic Society	Don C. Robertson, Orlando	Matthew A. Larkin, Miami	" " " " " "
Psychiatric Society	Samuel G. Hibbs, Tampa	Merton L. Ekwall, Jacksonville	" " " " " "
Radiological Society	John S. Stewart, Ft. Myers	Alfred G. Levin, Miami	" " " " " "
Surgeons, Am. Coll., Fla. Chapter	Donald W. Smith, Miami	Charles Larsen Jr., Lakeland	" " " " " "
Surgeons, General, Fla. Assn.	Richard M. Fleming, Miami	Emmet F. Ferguson Jr., Jacks'ville	" " " " " "
Urological Society	H. Lawrence Smith Jr., Tallahassee	Henry C. Hardin Jr., Miami	" " " " " "
Florida—			
Basic Science Exam. Board	P. A. Vestal, Winter Park	M. W. Emmel, Gainesville	Miami, June 10, '61
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Blue Shield of Florida, Inc.	Russell B. Carson, Ft. Lauderdale	John T. Stage, Jacksonville	Miami Beach, May 25, '61
Cancer Council	Joseph J. Zavertnik, Miami	Lorenzo L. Parks, Jacksonville	
Diabetes Association	Morris B. Seltzer, Daytona Beach	George F. Schmitt Jr., Miami	Miami Beach, Oct. 18-20, '61
Dental Society, State	Wallace Mayo, Pensacola	Munroe Farber, Vero Beach	Miami Beach, May 21-24, '61
Heart Association	Gibson Hooten, Clearwater	Mrs. Alvin Savage, Miami Bch	Miami Beach, May 27-28, '61
Hospital Association	Joseph F. McAloon, Hollywood	J. A. McDonald, Apalachicola	
Medical Examining Board	Robert T. Spicer, Miami	Homer L. Pearson Jr., Miami	Miami Beach, June 25-27, '61
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Public Health Association	Duke Peters, Jacksonville	Everett H. Williams Jr., Jacks'ville	Jacksonville, Oct. 5-7, '61
Thoracic Society	George H. McCain, Tallahassee	Dwight J. Wharton, Jacksonville	
Tuberculosis & Health Assn.	W. E. Arnold, Lakeland	Mrs. R. H. McIntosh, Port St. Joe	
Woman's Auxiliary	Mrs. John M. Butcher, Sarasota	Mrs. Richard V. Meaney, Palmetto	Miami Beach, May 25-28, '61
American Medical Association	E. Vincent Askey, Los Angeles	F. J. L. Blasingame, Chicago	New York City, June 25-30, '61
A.M.A. Clinical Session			Denver, Nov. 27-30, '61
Southern Medical Association	Edwin H. Lawson, New Orleans	Robert F. Butts, Birmingham, Ala.	Dallas, Texas, Nov. 6-9, '61
Georgia, Medical Assn. of	Milford B. Hatcher, Macon	John T. Mauldin, Atlanta	Atlanta, May 7-10, '61
S. E. Am. Urological Assn.	N. Lewis Bosworth, Lexington, Ky.	J. L. Campbell, Orlando	
S. E. Hospital Conference	Gene Kidd, Nashville, Tenn.	G. C. Long Jr., Montgomery, Ala.	
Southern Thoracic Surgical Assn.	DeWitt C. Daughtry, Miami	Hawley H. Seiler, Tampa	Memphis, Nov. 16-18, '61

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* *Bradford, Gilchrist, Union*				
Bay	John J. Hollomon, Panama City	A. Ralph Monaco, Panama City	1st Tues.	31
Brevard	Willard H. Bennett, Titusville	Frederick H. Lucas, Cocoa Beach	1st Tues.	73
Broward	Burns A. Dobbins Jr., Ft. Lauderdale	Frederick W. Fisher, Ft. Lauderdale	4th Tues.	265
Charlotte	Carl N. Reilly, Punta Gorda	Stephen R. Roddy, Punta Gorda	2nd Tues.	7
Clay	William A. Mulford, Green Cove Spgs.	Joseph G. Ritch Jr., Orange Park		10
Collier	William J. Bailey, Naples	Ethel H. Trygstad, Naples	4th Tues.	14
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.	12
* *Baker*				
Dade	Willard L. Fitzgerald, Miami	George W. Robertson III, Miami	1st Tues.	1063
DeSoto-Hardee-Glades	Harold S. Agnew, Arcadia	Elmer J. Schmierer, Arcadia	1st Tues.	15
Duval	Sidney Stillman, Jacksonville	Robert J. Brown, Jacksonville	1st Tues.	358
Escambia	P. G. Batson Jr., Pensacola	Vernon L. Smith, Pensacola	2nd Tues.	118
Franklin-Gulf	William F. Wager, Port St. Joe	Henry I. Langston, Apalachicola	Last Wed.	7
Highlands	Samuel A. King, Avon Park	Claude B. Henderson, Avon Park	3rd Mon.	13
Hillsborough	Herbert B. Lott, Tampa	Frank A. Massari, Tampa	1st Tues.	265
Indian River	Phil D. Morgan, Vero Beach	Walter W. McCorkle, Vero Beach	2nd Tues.	14
Jackson-Calhoun	Terry Bird, Blountstown	Francis M. Watson, Marianna	Quarterly	17
Lake	Lawton F. Douglass, Umatilla	Raymond A. Debo, Eustis	1st Wed.	35
Lee-Hendry	Jack C. W. Warnock, Ft. Myers	Richard W. Plummer, Ft. Myers	3rd Mon.	38
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Madison	Julian M. Durant, Madison	A. Franklin Harrison, Madison	1st Tues.	6
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Marion	Herbert M. Webb Jr., Ocala	Keith H. Knorr, Ocala	3rd Tues.	33
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Nassau	Henry B. Dickens Jr., Fernandina Bch.	John B. Britton, Fernandina Beach	1st Thurs.	11
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* *Dixie*				
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(1) Carter, S.: M. Clin. North America 37:315, 1953.
(2) Maltby, G. L.: J. Maine M. A. 48:257, 1957.
(3) Crawley, J. W.: M. Clin. North America 42:317, 1958.

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References: 1. Lineback, M.: The Eye, Ear, Nose and Throat Monthly *39*:342 (April) 1960. 2. Fuchs, A. M. and Maurer, M. L.: New York J. Med. *59*:3060 (August 15) 1959. 3. Kreindler, L. *et al.*: Antibiotic Med. and Clin. Therapy *6*:28 (January) 1959. 4. Schiller, I. W. and Lowell, F. C.: New England J. Med. *261*:478 (September 3) 1959. 5. Edmonds, J. T.: The Laryngoscope *69*:1213 (September) 1959. 6. Horstman, H. A.: Am. Pract. & Digest Treat. *10*:96 (January) 1959.

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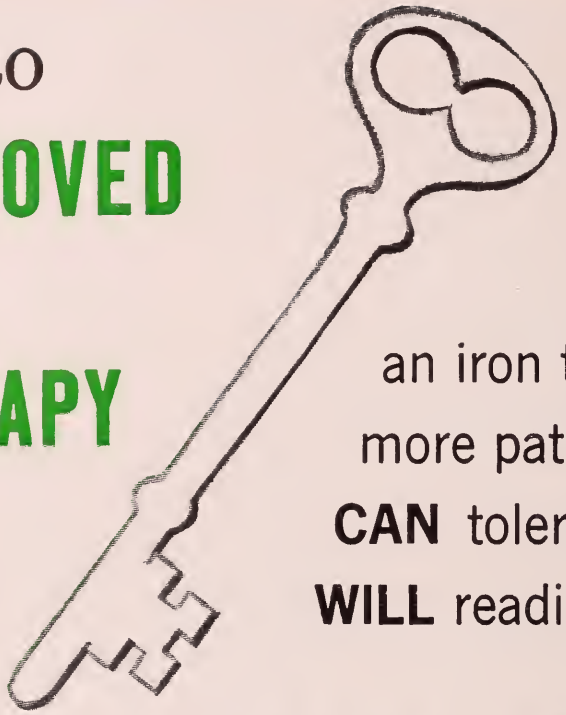
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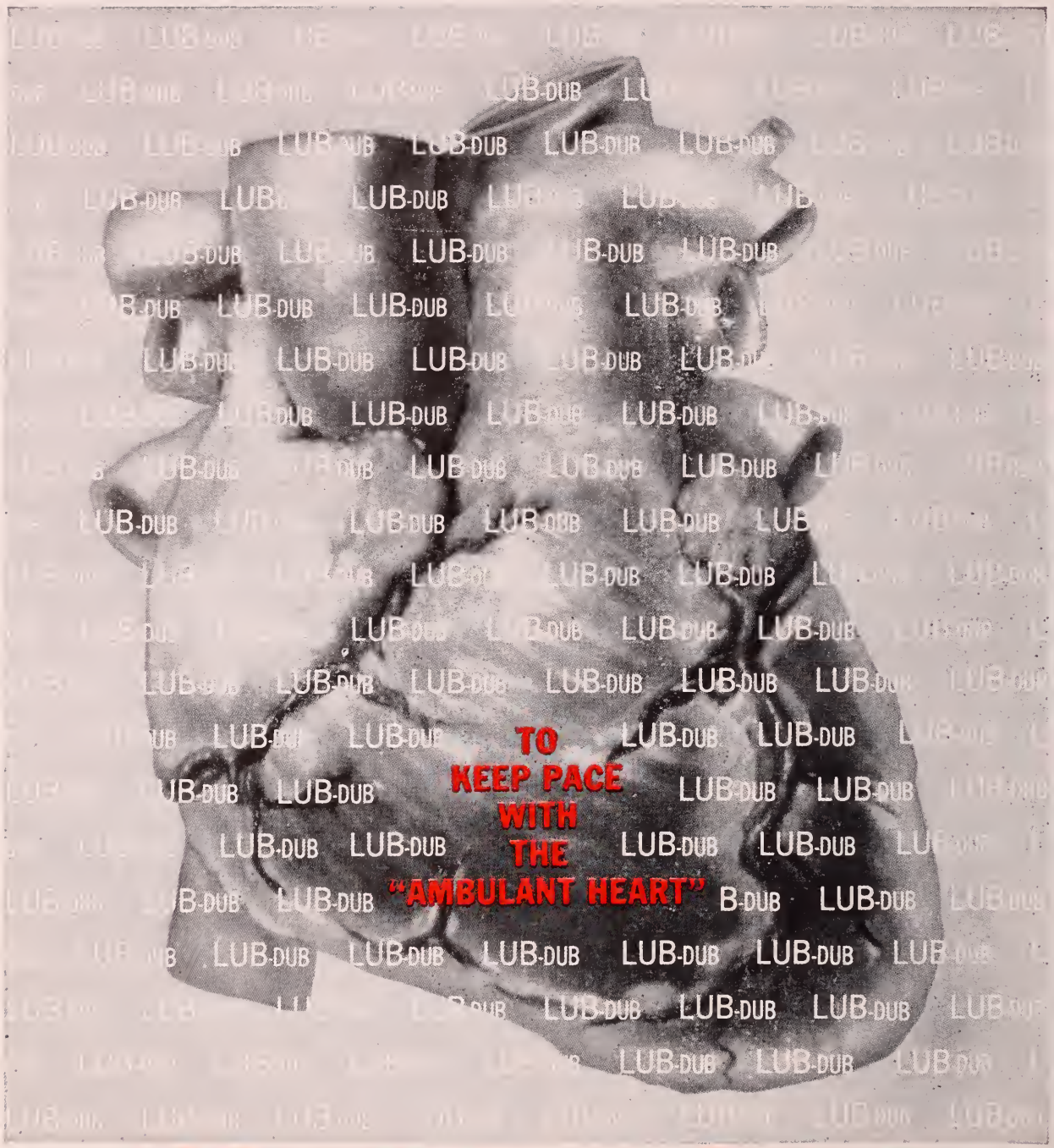
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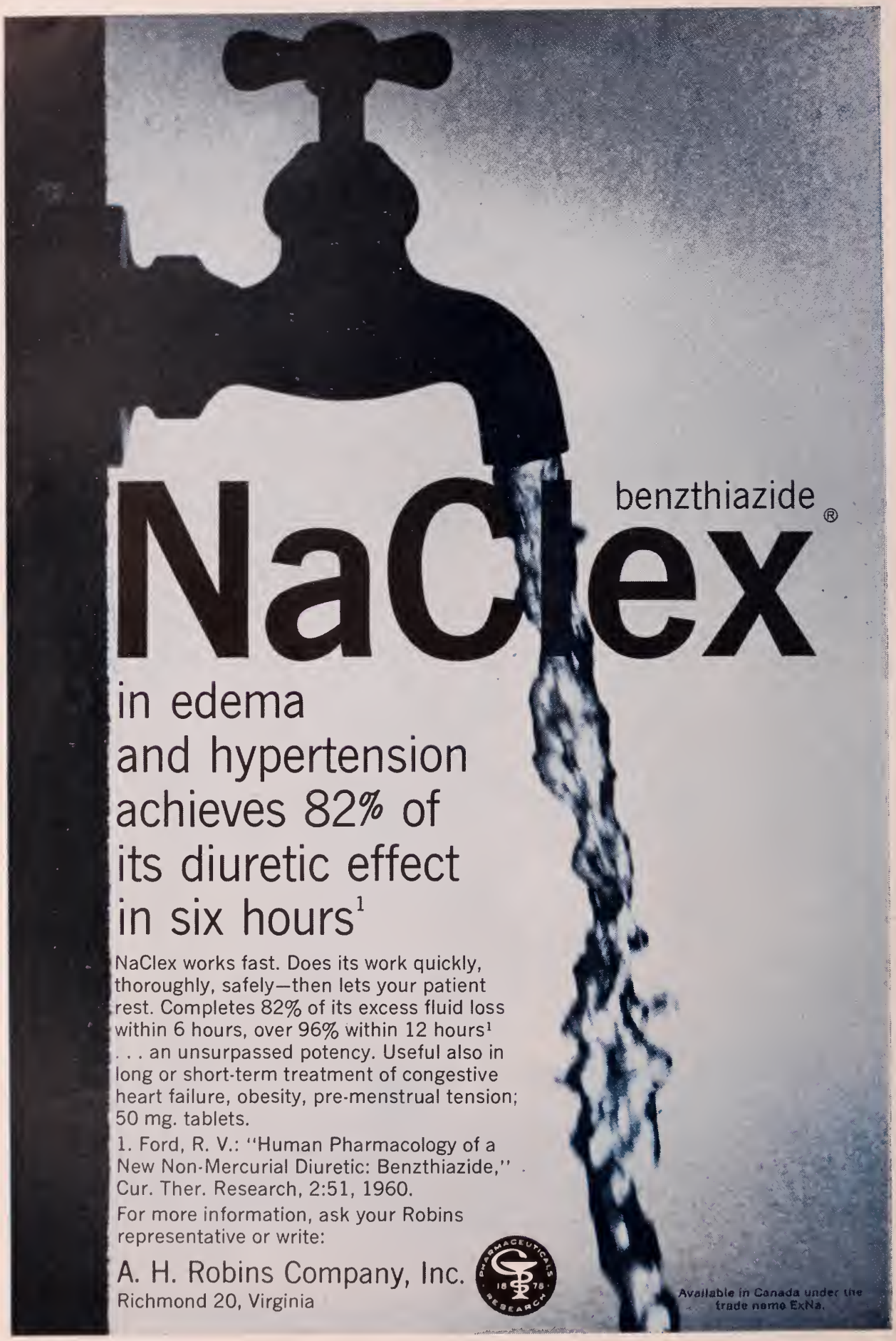
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1. Ford, R. V.: "Human Pharmacology of a New Non-Mercurial Diuretic: Benzthiazide," Cur. Ther. Research, 2:51, 1960.
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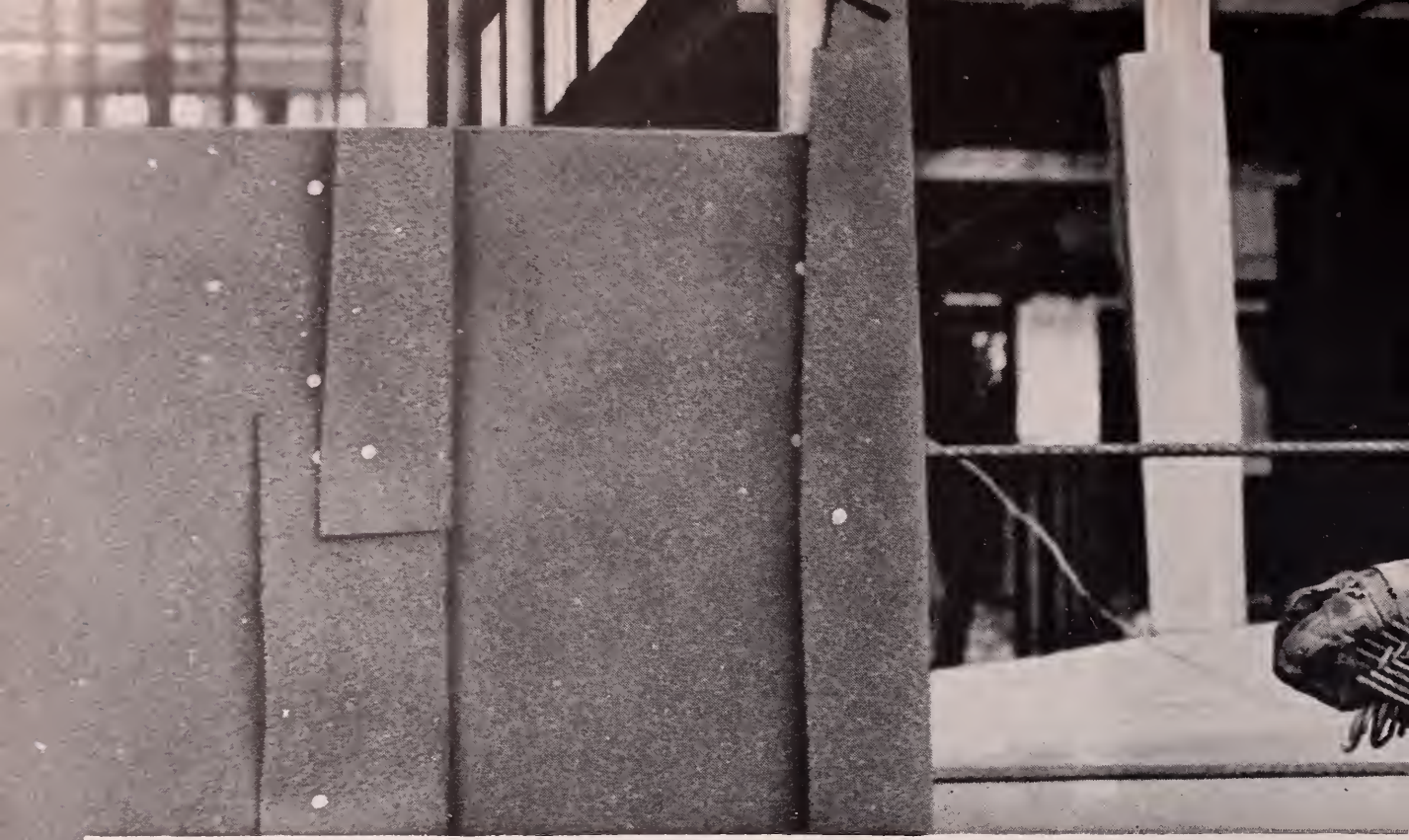
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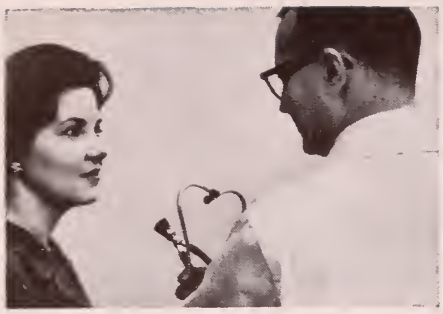
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*Gamble, C.J.: Am. Pract. & Digest. Treat. *11*:852 (Oct.) 1960. See also Berberian, D.A., and Slighter, R.G.: J.A.M.A. *168*:2257 (Dec. 27) 1958; Kaufman, S.A.: Obst. and Gynec. *15*:401 (March) 1960; Warner, M.P.: J.Am.M. Women's A. *14*:412 (May) 1959.

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Blowout Fracture of the Floor of the Orbit

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NEW YORK

The purpose of this paper is to describe a condition which we designate as "blowout fracture" of the floor of the orbit.[1] This type of fracture is caused by a sudden increase of intraorbital pressure resulting from the application of a traumatic force over the orbital area. The inferior rectus and inferior oblique muscles are herniated through a dehiscence in the orbital floor, and diplopia results from the vertical muscle imbalance; the escape of orbital fat through the blowout dehiscence is the major cause of enophthalmos. The blowout fracture occurs more frequently than generally assumed and is often overlooked by plastic surgeons and ophthalmologists.

Mechanism of Production

It will be recalled that the floor of the orbit, in its posterior half, shows an area of thin bone situated immediately anterior to the inferior orbital fissure. This area is further weakened by the infraorbital groove or canal. This "weak area" of the orbital floor can be demonstrated by transillumination of the dried skull.

The orbit as seen on cross section is cone-shaped. The floor of the orbit extends backward and upward on an inclined plane, and the thin portion of the floor is situated in the posterior portion of the inclined plane. When the orbital contents are pushed backward, they must be made to fit into a smaller area, and the increased internal pressure thus exerted causes a "blowout" at the "weak area" of the orbital floor.

In its most typical form the blowout fracture occurs without fracture of the thick orbital rim, following the application of a traumatic force over the orbital contents by a nonpenetrating object such as a large ball or the human fist. The ocular globe appears to be capable of withstanding considerable compression without rupturing, in such injuries. It is characteristic that in injuries sustained by a golf ball, the smaller size golf ball usually produces a rupture of the ocular globe.

In another form, the blowout fracture occurs in conjunction with comminution of the bones of the orbital rim, principally the lateral and inferior rim formed by the zygomatic and maxillary bones. The striking force, after fracturing the bones, continues in its progression backward causing pressure on the orbital soft tissue structures, thus producing a concomitant blowout fracture. This type of fracture is typical of the dashboard automobile crash injury.

The mechanism of production of the blowout fracture of the orbital floor was reproduced experimentally and verified in the cadaver by duplicating a force similar to the force that had produced a blowout fracture in one of our patients injured by being hit by a ball used in the Irish game of hurling.[2]

The hypotony of the cadaver globe was corrected by intraocular injection of normal saline solution. A hurling ball was placed over the closed lids of the cadaver orbit and the ball was struck

From the Institute of Reconstructive Plastic Surgery, New York University Medical Center and the Plastic Surgery Clinic, Manhattan Eye, Ear and Throat Hospital, New York, N. Y.
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sharply with a hammer. A cracking sound was heard and was interpreted as caused by fracturing bone. An exploratory incision through the skin at the infraorbital margin, and elevation of the orbital contents from the floor, exposed a depressed comminuted fracture of the floor of the orbit. Exenteration of the orbital contents showed the fracture in its entirety. There was also a comminuted fracture without displacement involving the lamina papyracea of the ethmoid bone. No fracture of the orbital rim or zygomatic arch was observed. This duplicated almost exactly the injury sustained by our patient.

In a second experiment, the opposite orbit of the cadaver was exenterated. The soft tissue covering the orbital rim was excised to allow direct contact between the bony orbital rim and the surface of the hurling ball. Repeated blows of similar force with the hammer failed to fracture the floor or the rim of the orbit. When the striking force was sufficiently increased, the orbital rim and orbital floor were comminuted simultaneously.

As a result of the blowout of the floor of the orbit, the soft tissue contents of the orbit including the inferior rectus and inferior oblique muscles and Tenon's capsule may become herniated and incarcerated into the maxillary sinus through the hole in the orbital floor. There is a varying amount of reaction and hemorrhage depending upon the extent of the damage done. If the periorbita is torn, orbital fat escapes into the maxillary sinus. Since the action of the inferior oblique is elevation, abduction and extorsion, and that of the inferior rectus, depression and adduction, it can readily be concluded that extorsion will be restricted while elevation, depression, abduction and adduction may all be limited to a variable degree. The involvement of these two extraocular muscles, the inferior rectus and the inferior oblique, explains the consistency of vertical muscle imbalance, which has been noted by us and by others who have studied traumatic diplopia.[3-5]

The most common fracture site in the blowout fracture of the orbital floor is the portion of the floor which is weakened by the infraorbital canal or groove. The inferior oblique muscle arises from the orbital floor near the lateral margin of the lacrimal groove, and the inferior rectus muscle is situated immediately above the infraorbital canal on the under surface of the orbital contents. It is easy to understand, therefore, that these two muscles are frequently involved in the blowout fracture. Absence of elasticity in the impounded inferior rectus muscle restricts rotation in the field of action of its antagonist, the superior rectus. Because the two muscles are intimately fused at the point where the inferior oblique crosses beneath the inferior rectus, disturbance of function of the inferior oblique muscle is usually observed in blowout fractures. When the blowout fracture is located laterally to the infraorbital groove or canal, the inferior rectus and inferior oblique muscles may not be involved. These variations in the site of the blowout fracture explain variations in symptoms and signs in these fractures.

Injury to the motor nerves of the inferior oblique and inferior rectus muscles must also be considered. The inferior oblique is supplied by the inferior division of the third cranial nerve which courses along the lateral border of the inferior rectus muscle to enter the inferior oblique in its middle portion. This nerve is exposed to injury in blowout fractures.* The relatively short course of the nerve to the inferior rectus renders it less vulnerable to injury.

The typical blowout fracture is not seen in the fracture-dislocation of the zygomatic bone where the bone is displaced as a single fragment. In such a fracture the site of impact is lateral to the orbital cavity, and the orbital contents are not directly injured. The majority of cases of transient diplopia following fracture of the zygoma studied by Barclay[5] were fracture dislocations of the zygoma with displacement of the bone as a single fragment. Transient diplopia in such fractures is usually attributed to hemorrhage and edema disturbing the visual axis by elevating the ocular globe on the affected side. Barclay's analysis of the cases in which diplopia persisted showed that four out of the 13 patients had comminuted fracture of the orbital floor. A study of the table in which Barclay summarized the findings shows that all of the 13 patients, with the exception of one in whom the diplopia was caused by a paralysis of the lateral rectus muscle, showed diplopia in the upper fields. It is suggestive that a good proportion of these fractures might have been diagnosed as blowout fracture with incarceration of the inferior rectus muscle into the orbital floor fracture.

Clinical Diagnosis

In the typical blowout fracture the patient complains of diplopia particularly when he looks

*A recent electromyographic study in a blowout fracture showed absence of response in the inferior oblique with normal response in the superior rectus muscle.

upward. Examination shows varying degrees of ecchymosis and edema, and the ocular globe occasionally gives the appearance of being displaced backward and downward. The supratarsal fold in the affected eye may be deepened. When an object is held approximately 2 feet away from the patient's eye and the patient is asked to look at the object, it is noted that the affected eye is unable to rotate upward in the normal range as does the unaffected eye; restriction in rotation downward and laterally is also often observed. In addition to these signs of interference with inferior rectus function, limitation of rotation of the affected eye upward and inward indicates malfunction of the inferior oblique muscle. In a child, we observed nearly complete fixity of the globe. Traction applied to the eyeball by means of forceps shows that the ocular globe cannot be elevated with the forceps applied to the tendon of the inferior rectus. This test, known as the *traction test,* gives a means of differentiating contracture or adhesion of the inferior rectus from weakness or paralysis of the superior rectus, and it constitutes the best means of diagnosis of incarceration of the inferior rectus and the blowout fracture syndrome.

Anesthesia or hypoesthesia in the area of distribution of the infraorbital nerve is an indication of blowout fracture involving the infraorbital groove or canal. This sign is useful in making a diagnosis when the orbital rim is not fractured, and also assists in locating the site of the blowout: normal infraorbital nerve conduction implies that the fractured area is either lateral or medial to the infraorbital groove or canal.

Radiological examination usually shows a cloudy maxillary sinus because of hematoma. The x-ray in the Waters view frequently shows downward herniation of the orbital contents. A laminagram may delineate more clearly the herniation due to blowout fracture of the orbital floor.

Even in the absence of positive radiological signs the presence of a sufficient number of the clinical signs previously described and in particular inability to rotate the ocular globe upward, with a positive traction test, should make the surgeon suspicious of the presence of a blowout fracture. Surgical exploration is indicated.

The maxillary sinus is a natural approach to the orbital floor, the roof of the maxillary sinus forming the major portion of the floor of the orbit. Through a Caldwell-Luc approach in the canine fossa the interior of the sinus may be examined. The opening should be large enough to insure direct inspection and palpation of the orbital floor. The presence of a blowout fracture will be evident when a hole is noted in the floor of the orbit through which orbital contents are herniated; in other cases palpation reveals only that the orbital floor is crepitant and soft. In severely comminuted fractures the periorbita may be ruptured and orbital fat fill the maxillary sinus. Fragments of loose bone are also found in this type of fracture, and the maxillary sinus approach permits their removal.

After evidence of disruption of the floor of the orbit is observed through the maxillary sinus approach, more adequate exposure of the orbital floor is obtained through an incision made in the lower eyelid.

The blowout fracture shows variations in the type of fracture. A single fragment of the thin portion of the floor may have been projected downward into the maxillary sinus as though it had been punched out. In another type, the bone fragment remains hinged on one of its sides, the detached piece hanging downward into the sinus. In two of our cases comminution over a fairly wide area of the weak portion of the floor of the orbit was noted. In this type of fracture the orbital floor sags downward, the multiple pieces of bone remaining attached by the periosteum. The orbital contents have not actually penetrated the maxillary sinus, being separated from the maxillary sinus by the comminuted floor which hangs like a hammock into the sinus. In one of these cases the zygoma showed comminuted fractures involving the orbital rim, and there was also a fracture of the maxilla (Le Fort II). In one of our cases examination of the floor of the orbit through the maxillary sinus failed to reveal any pathologic condition, but the positive traction test was a sufficient indication for exploration of the floor of the orbit through the eyelid. This approach revealed a linear fracture through the weak portion of the floor of the orbit in which the inferior rectus had become incarcerated. In another case, in which the only sign of fracture was interference of function of the inferior rectus, a sharp fragment of the weak portion of the orbital floor was found to have penetrated the inferior rectus muscle, pinning the muscle to the orbital floor. In the majority of cases the weak portion shows an area of comminution with the intact orbital floor on each side; occasionally the entire orbital floor is comminuted.

It must be emphasized that the thin portion of the orbital floor is located in the posterior half of the orbit and that the presence of an intact orbital rim and anterior portion of the floor of the orbit might mislead the surgeon into believing that the entire floor is intact.

The following history of a patient referred to us for late reconstruction of the floor of the orbit is typical:

> The patient was seen on Jan. 23, 1957, three days after an automobile accident. There were extensive abrasions and lacerations about her right eye and cheek, which had been cared for previously. The right side of the face was markedly edematous, to the point that the ocular globe could not be seen. An ophthalmologist was already in attendance in regard to the eye. X-rays revealed a fracture of the right zygoma with minimal displacement. As the edema subsided and the ocular globe became visible, the patient experienced some diplopia. The globe itself did not seem to be displaced, but there was impairment of extraocular muscle function, particularly the inferior oblique and inferior rectus muscles. Consequently, the fracture site at the infraorbital margin was explored on February 4 in collaboration with the ophthalmologist.
>
> At operation, there was severe comminution of a 1 cm. segment of the infraorbital rim, but the zygoma itself seemed to be in good position. The anterior portion of the bony floor of the orbit was explored and the fracture line was identified. The anterior floor seemed to be in good position and well supported. Several days postoperatively early enophthalmos was noted. This continued to develop, the eye dropping to a slightly lower plane, and the diplopia became more pronounced.
>
> Reconstructive surgery to restore the floor of the orbit was recommended.
>
> We operated upon this patient recently (Sept. 11, 1959) and found the typical lesion of the blowout fracture with herniation of orbital contents through the fracture site in the weak area of the floor. The orbital soft tissues were freed and the bony defect was bridged by means of an iliac bone graft. Upon release of the orbital contents, the ocular globe could be rotated upward; prior to this operation, as revealed by the traction test, upward rotation was restricted.

Exposure of the floor permits a more direct approach to the fracture site and a bimanual replacement of the orbital contents into the orbital cavity in cases of gross herniation. After the orbital contents have been pushed upward from the interior of the maxillary sinus by the surgeon's finger, a retractor placed under the orbital contents maintains them elevated until the gap in the floor of the orbit can be closed by means of a bone graft. The restoration of the continuity of the orbital floor prevents a recurrence of the herniation of the orbital contents through the dehiscence at the site of the blowout fracture. In one of our cases which was treated successfully, the orbital contents were pushed up into the orbit and were maintained in position by maxillary sinus packing. We think, however, that in most cases the use of packing alone, or of an inflatable balloon in the maxillary sinus, while a useful adjunct to treatment particularly in comminuted fractures involving the maxilla and zygoma, is not a sufficiently positive method. The antral pack restores the level of the sagging floor, but fails to offer any solution to the essential lesion, the adherence of the orbital contents to the floor of the orbit which interferes with function of the extraocular musculature.

Discussion

The mechanism of the blowout fracture was suspected in 1943 by Pfeiffer, who found by radiological study that in a series of 120 fractures of the orbit, the floor alone was implicated in 24 cases without involvement of other facial bones. He pointed out the remarkable degree of violence that can be withstood by the ocular globe itself in such injuries. De Voe,[7] in 1947, described a fracture similar to a blowout fracture in which a fracture of the orbital roof was accompanied by a splintering of the orbital floor. That same year, Neely[3] noted the predominance of diplopia in the upper fields, and Schjelderup,[4] in 1950, expressed the opinion that in most instances diplopia is caused by adhesions or pinching of the orbital contents in the fracture lines of the orbital floor.

In correcting cases of persistent late diplopia by means of orbital floor bone grafts with the primary intention of raising the orbital contents to a level comparable with that of the opposite eye, we[8] had noted that in many of the patients, dissection of the orbital contents from the floor was somewhat difficult, and that frequently the orbital contents were incarcerated in defects in the floor. We submit that the gradual disappearance of diplopia which occurred in these cases following bone grafting was essentially the result of freeing the incarcerated soft tissues, thus permitting a return of adequate function of the extraocular musculature. We agree with Barclay[5] when he reminds us that double vision results from interference with the action of one or more extrinsic muscles of the eye and that ptosis of the eyeball alone is not a cause of diplopia.

Many blowout fractures are overlooked because of the fact that diplopia may be the only symptom in the absence of signs of fracture. Occasionally the diplopia is compensated for by a remarkable degree of binocular fusion even if the displacement of the globe is considerable. The relative difficulty of the radiological diagnosis also tends to exclude the diagnosis of fracture.

A fracture of the paper-thin portion of the floor of the orbit occurring without involving the stout orbital rim or other bones of the face is probably a much more common event than is generally supposed.

Enophthalmos

In a previous publication we[1] emphasized the need for preventive treatment of traumatic enophthalmos. We attributed the causation of traumatic enophthalmos to two mechanisms: (1) the enlargement of the orbital cavity, the orbital fat being distributed in a larger cavity and no longer sufficing to support the ocular globe, and (2) the escape of orbital fat into the maxillary sinus. The prevention of enophthalmos requires restoration of the continuity and suitable level of the floor of the orbit. Diagnosis of blowout fracture and restoration of the floor of the orbit by bone grafts will prevent enophthalmos.

Treatment of Blowout Fracture

In the 15 cases observed by us all patients but one were operated upon. The one exception was an adult with a history of a fist blow over the orbital contents and radiological evidence of a blowout fracture consisting in only a slight depression in the weak area of the orbital floor. This patient showed no diplopia or interference with the movements of the ocular globe. In the absence of positive signs of disturbed extraocular musculature we abstained from surgical intervention.

The remaining group of 14 patients varied in age from six years to 57 years and showed varying degrees of muscle imbalance with a positive traction test. In these patients the orbit was explored surgically and treated through the maxillary sinus approach, or through an incision in the eyelid to expose the orbital floor, or by a combination of these two methods.

A child, aged 10, with diplopia and a positive traction test, was treated successfully by pushing the herniated orbital contents upward through the opening in the orbital floor and maintaining the hinged fragment in position by means of gauze packing placed in the maxillary sinus.

In all other cases, surgical treatment consisted of exposure of the orbital floor from above through an incision in the lower eyelid. The incision is made in a natural skin fold of the lid. The skin of the lid is raised from the orbicularis oculi fibers over a distance of a few millimeters below the incision, the fibers of the orbicularis are split, and the rim of the orbital floor is exposed. Penetration through the septum orbitale is avoided, and the outer surface of this fascia is followed down to its insertion on the rim of the orbit. The periosteum is incised, and the orbital contents are raised with the periosteum from the orbital floor. The site of the blowout fracture is usually indicated by the herniated orbital tissues. These must be extricated from the fractured area. The herniated orbital contents are pushed up from the maxillary sinus through the opening in the orbital floor. A retractor maintains the orbital tissues elevated until the gap in the orbital floor can be closed. It is noted at this stage that the ocular globe can be freely rotated upward by means of traction applied to the tendon of the inferior rectus.

Restoration of the floor of the orbit after freeing of the adherent soft tissues is indicated in order to prevent a recurrence of the herniation of the orbital contents into the rent in the orbital floor. A small piece of iliac bone taken from the inner table of the bone has been our choice in most of the cases. In children the bone graft was removed from the inner table of the ilium below the level of the cartilaginous crest. In two patients in whom there was a small defect, the anterior wall of the maxillary sinus in the canine fossa was employed to restore the continuity of the floor. In one case in which the major portion of the floor was comminuted, a large bone graft was used to restore the major portion of the orbital floor. We have preferred autogenous bone because of its rapid consolidation in a defective area which communicates directly with the maxillary sinus.

Relief of the vertical extraocular muscle imbalance and of diplopia in the upper field was immediate and complete in some cases; in others it was progressive and incomplete extending over a period of months.* The rapidity of the return of satisfactory range of ocular globe motility appeared to be somewhat dependent upon how soon after injury treatment could be instituted. The time interval between injury and treatment varied from a few hours to 12 days. The earlier the treatment, the more rapid the return of function.

No appreciable enophthalmos was observed in any of the patients in the series of 15 cases reported in this paper.

Summary

The blowout fracture of the floor of the orbit produced by an increase of internal orbital pres-

*Detailed studies of the extraocular muscle findings in blowout fractures will make the subject of a later report.

sure from an external trauma may result in the herniation of the soft tissues of the orbit through the "weak area" of the orbital floor situated anteriorly to the inferior orbital fissure. The incarcerated orbital contents restrict the movements of the ocular globe, particularly in upward rotation; this lesion is the essential cause of diplopia in fractures of the floor of the orbit. When the opening in the orbital floor is wide enough and when the periorbita is torn, orbital fat escapes from the orbital cavity into the maxillary sinus and enophthalmos ensues.

Treatment of the blowout fracture of the floor of the orbit consists of freeing the herniated orbital contents in order to restore free movement of the ocular globe, and of re-establishing the continuity of the orbital floor by means of a bone graft. Our experience in the early diagnosis and treatment of a blowout fracture of the floor of the orbit in 15 patients is described.

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Not too many years ago parents watching the physician as he examined their baby knew as well as the physician did that before their child reached adulthood, he would have to survive potentially devastating infections. Since the baby had to do so mostly on his own without help of immunizations and antibiotics, many did not survive. No one, physician or parent, really considered neoplastic disease a threat to survival of an infant through his early years. Quickly, during the recent years of antibiotics, this situation has become reversed. Cancer now is second only to accidents as a cause of death in childhood. From 1922 to 1924 under 2 per cent of deaths that occurred between one and 15 years of age were due to malignant neoplastic disease; in 1946 and 1947, one in every nine deaths in the zero to 14 year age group was due to cancer.[1] Neoplasms of the chest and abdomen are responsible for a considerable portion of these deaths. They are encased in the body cavities where they do not easily arouse attention. The purpose of this paper is to emphasize the tumors commonly encountered in the chest and abdomen of children, and to point out methods for their detection and management.

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Types of Tumors

In adults, tumors most often encountered in the chest and abdomen have a mucosal origin—respiratory tract and esophagus in the chest, gastrointestinal tract in the abdomen. Mucosal tumors, other than cysts and polyps, are rarely encountered in children. No case of malignant neoplasm arising from the lining epithelium of the respiratory or intestinal tract is recorded in the tumor registry of the Children's Memorial Hospital in Chicago from 1950 through 1959.[2]

In children, tumors arising in these two principal body cavities mainly represent embryonal rests of tissue. These may occur in any organ, but are found most often in the lung, kidney, sympathetic nervous system, liver, thymus gland, ovary, and muscle. The vast majority (60 to 70 per cent) of these tumors arise in the kidney or sympathetic nervous system.

Methods for Detection

The baby with a tumor in the chest or abdomen cannot say "my side hurts," or "my trousers

fit tightly." He cannot call his mother's attention to the early symptoms of neoplastic growth which are made familiar to every literate adult today through the different cancer educational programs. The observant parent, however, will often notice changes in the child and actually direct the attention of the examining physician to them—poor appetite, occasional difficulty with respiration, paleness, lethargy, easy fatigability, and the prominence or enlargement of a side or part of the abdomen. Perhaps while changing diapers the mother thought she felt a lump in the side. Such vague observations registered by a parent are often the earliest detectable signs of a tumor hidden in the thorax or abdomen. Digestive complaints, cough with hemoptysis, and changes in bowel habits, while helpful in suspecting malignant disease in the adult, are rarely so in the child. One must be more highly suspicious and investigate more thoroughly persistent vague deviations from the normal pattern of growth and activity.

Nothing is so valuable in detecting the presence of a tumor in childhood as the periodic physical examination. Many of the tumors present no symptoms until they are very large, or until metastases are widespread. The examining hand of the careful physician, however, may detect the tumor still contained in its capsule. As he observes a baby, he may note a Horner's syndrome caused by pressure of a posterior mediastinal tumor.

Second in line of value in detecting tumors in the thorax or abdomen of children is the x-ray. Many of these neoplasms will be brought out clearly on the routine x-ray pictures of the chest. The nerve tissue tumors in the chest, neuroblastoma and ganglioneuroma, usually are located posteriorly in the paravertebral gutter. Dermoid and teratoid tumors along with thymomas will be seen in the anterior mediastinum. The intravenous pyelogram is of inestimable value when an abdominal mass is suspected. Wilms' tumor and neuroblastoma form a large part of abdominal tumors in childhood. The Wilms' tumor characteristically distorts the renal pelvis by encroachment from the expanding capsule of the tumor. Neuroblastoma arising in the adrenal gland or retroperitoneal sympathetic nerves may displace the kidney and distort the renal pelvis, but less often than Wilms' tumor. These tumors more commonly than Wilms' tumor will show on the X-ray scattered deposits of calcium. Far different from the case in adults, the barium enema and gastrointestinal x-ray series will infrequently serve to establish the presence of a tumor in children. Considering the origin and location of these childhood tumors, this fact follows.

Table 1. — Tumors of the Chest and Abdomen Commonly Encountered in Infants and Children (Benign and Malignant)

Type of Tumor	Number of Cases*
Neuroblastoma	38
Wilms' tumor	33
Teratomas (mediastinal, retroperitoneal and sacrococcygeal)	
Ganglioneuroma	
Ganglioneuroblastoma	5
Dermoid (mediastinal)	
Hepatoblastoma	4
Sarcoma of the stomach	1
Rhabdomyosarcoma of the pelvis	1
Carcinoma of the ovary	1
Angiosarcoma of the kidney	1
Thymoma (malignant)	1

*Represents number of cases in tumor registry of Children's Memorial Hospital, Chicago, 1950-1959.

Table 2. — Statistical Data:* Percentage Survival Without Metastasis of All Patients Treated

Type of Tumor	Number of Patients	Per Cent Survival
Neuroblastoma	38	39
Wilms' tumor	33	48
Ganglioneuroblastoma	5	60
Hepatoblastoma	4	25
Sarcoma of the stomach	1	0
Rhabdomyosarcoma of the pelvis	1	100
Carcinoma of the ovary	1	0
Angiosarcoma of the kidney	1	0
Thymoma (malignant)	1	0
Total number of patients with malignant tumors	85	42

*Tumor registry, Children's Memorial Hospital, Chicago, 1950-1959.

Management

Prompt surgical removal of the tumor following reasonably early diagnosis offers the best chance for survival of the child. In this young age group, survival time has a different meaning than in the adult. A 65 year old man with carcinoma of the colon, regardless of his opportunity for five year survival from the tumor, is already close to his average life expectancy. The one year old baby has a life expectancy of about 70 years.

Principles for cancer surgery are the same in the child as in the adult. Owing to the location of these tumors, however, and to the fact that all too often they are not discovered until the tumor has achieved large dimensions, excision with a wide margin of normal tissue is often not possible. Not infrequently, incomplete tumor removal will provide many months of active, playful life, par-

ticularly if the tumor or its metastasis is radiosensitive. Occasionally with neuroblastoma, years of successful palliation and sometimes even a cure will be achieved with this approach. Neuroblastoma, particularly if discovered when the child is under two years of age, may often be successfully palliated with large doses of vitamin B_{12}.[3] Strangely enough, neuroblastoma will occasionally under palliative treatment with x-ray and/or vitamin B_{12} undergo a cell transformation into the benign ganglioneuroma. The tumor may then be surgically removed. In certain instances, nitrogen mustard is helpful in the palliative management of neuroblastoma.

When the statistics in table 2 are broken down according to age, it is seen that with both neuroblastoma and Wilms' tumor survival is much higher in the babies who are below two years of age when the tumor is discovered.

Summary

Neoplastic disease is responsible for a large proportion of deaths during infancy and childhood. Thoracic and abdominal tumors are an important part of this neoplastic disease. These tumors are infrequently seen in adults, and their diagnosis and management require somewhat different technique and approaches than those used for adult neoplastic disease.

References

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Discussion

DR. JAMES A. WHITESIDE, Coral Gables: Dr. Wilkinson has presented well the significant problem of malignant disease in childhood by summarizing the experience of the tumor registry at Children's Memorial Hospital, Chicago, from 1950 to 1959, and outlining the salient features of the more common malignant tumors presenting in the chest and abdomen. It must be commented again that the early diagnosis of tumors in children is proportional to the combined acuity of the parents and the physician. Certainly, proper education of parents as well as re-education of physicians regarding the warning signs and symptoms of these neoplasms, similiar to the cancer program in adults, is mandatory.

The experience, as outlined by Dr. Wilkinson, that neuroblastoma and Wilms' tumor combine to constitute the greatest number of chest and abdominal tumors is comparable to data from other pediatric centers. Often these two malignant lesions are spoken of in the same light. Actually, their dissimilarities outnumber their likenesses. Aside from being unlike histologically, neuroblastoma arises from nervous tissue and can be found along any sympathetic chain, whereas Wilms' tumor arises from kidney parenchyma only. As a rule of thumb, neuroblastoma arising in the abdomen will metastasize distantly to bone first, while Wilms' tumor more often metastasizes to the lung initially. Oftentimes, characteristic rosette patterns are found in the bone marrow of patients with neuroblastoma, but no distinctive cells are identifiable usually in the marrow of patients with Wilms' tumor. Neuroblastoma, at times, can mimic acute lymphoblastic leukemia, but Wilms' tumor does not. Both malignant tumors are mildly radiosensitive and may respond to chemotherapy, but only neuroblastoma is known to regress to a benign form spontaneously or when attacked surgically or with other physical measures. Recent work from Memorial Center in New York City points up the superior response of metastatic Wilms' tumor over neuroblastoma to the chemotherapeutic agent actinomycin D. Unfortunately, the successful experience of Bodian with large doses of vitamin B_{12} in the treatment of neuroblastoma has not been duplicated to complete satisfaction in this country. Although contrasting pictures may be present, even the trained oncologist with the abdomen open may not be able to differentiate between these neoplasms.

These malignant tumors should be attacked expeditiously and vigorously with all the tools and finesse of surgical and medical cancer knowledge. The laissez faire attitude has no place in the philosophy of management of children with neoplastic disease. The treatment of choice for both entities is the surgical removal of all or as much of the tumor as possible even in the face of distant metastases followed by irradiation and/or chemotherapy. There the treatment must not end. Too often after the stitches are out and the specific therapy completed; the patient is allowed to slip from diligent follow-up care. These patients are deserving of combined medical-surgical long term surveillance in order to combat progressive disease and the inevitable complications. Such services are rendered best, in the larger areas, by a group representing the various specialties banded together because of a sincere interest in pediatric oncology. Such a unique arrangement exists at Variety Children's Hospital in Miami.

Even though it is not Dr. Wilkinson's aim to discuss all of the possible neoplasms which might arise in the chest and abdomen, two other entities occur with a frequency frightening enough to warrant consideration. First of all, pure lymphosarcoma does occur in childhood and often presents in the mesenteric nodes and retroperitoneal space or the superior mediastinum. This neoplasm is amenable to surgery, irradiation, nitrogen mustard and/or other chemotherapeutic agents. A childhood variation of this lymphoma is lymphosarcoma complicated by acute leukemia somewhere along the course of the disease. More often this leukemic phase occurs toward the terminal stage of the disease.

The second category necessitating consideration when one is diagnosing masses in the abdomen is acute leukemia. Tight-fitting clothes noted by the parents may direct the attention of the physician to the enlarged liver and spleen even before anemia and petechiae are recognized. In children, acute leukemia can occur without significant organopathy, but more often than not, some element of bulky disease is also noted. Theoretically, if pure lymphosarcoma is placed at one end of the spectrum and pure leukemia at the other, a bell-shaped curve might be drawn indicating many such pediatric patients have elements of both diseases.

The reason these last two entities are not listed in the registry as presented by Dr. Wilkinson probably is that these diseases were not classified with solid tumors but were listed with the hematological neoplasms.

The experience of the Tumor Clinic at Variety Children's Hospital in the two years of its existence might give additional light on this problem of malignant disease in childhood. This clinic is staffed by practicing physicians who act collectively as a diagnostic team as well as a therapeutic battery. Many patients are referred because of a high index of suspicion on the part of the initial physician, yet the list of miscellaneous, nonmalignant, nontumor diseases is small. It includes:

Hirschsprung's disease	3
Hemorrhagic cystitis	1

Baker's cyst	1
Foreign body, cheek (BB shot)	1
Keloid formation	1
Ehlers-Danlos syndrome	1

The nonmalignant tumor group is more formidable. It includes:

Hemangioma (all types)	14
Lymphangioma	6
Neurofibroma	2
Benign lymphadenopathy	2
Osteochondroma	1
Hamartoma, liver	1
Lipoma, buttocks	1
Dermoid, head	1
Banti-like syndrome	1
Eosinophilic granuloma	1
Hand-Schüller-Christian disease	1

The malignant group in just two years of operation is compiled as:

Leukemia (all types)	20
Neuroblastoma	5
Lymphosarcoma	3
Wilms' tumor	3
Hodgkin's disease	1
Teratocarcinoma, testicle	1
Osteogenic sarcoma	1
Adenocarcinoma, kidney	1
Medulloblastoma	1
Astrocytoma	1
Lymphoepithelioma	1

Dr. Harry M. Edwards, Ocala: I would like to congratulate Dr. Wilkinson on his excellent presentation of a difficult subject. It am sure that no one is more conscious of the difficulty in the diagnosis of neoplasms of the chest and abdomen, in their early stages, than the pediatrician. He also realizes the importance of early detection when treatment is more favorable, because it often falls to his lot to care for the patient in the terminal stages.

We have seen only one malignant tumor of the abdomen in nearly nine years of pediatric practice in Marion and surrounding counties. This was a Wilms tumor discovered on routine physical examination and no symptoms referable to the tumor were present. Treatment consisted of surgical removal and follow-up radiation therapy. The child is living and well five and one-half years later. I would like to point out that intravenous pyelograms are not only important in detection of Wilms' tumors, but also show the presence and condition of the other kidney should surgical removal of the affected kidney be carried out.

In our experience, tumors of neural origin have been the most common. In contrast to the presented series, these have not been found in the chest or abdomen. We have seen one neuroblastoma arising from the head, one astrocytoma of the cerebellum and two medulloblastomas. The child with an astrocytoma is living eight years later, but has major convulsive seizures. One of the patients with medulloblastoma is living six months after detection of the tumor, and the other two have expired. In our experience the detection of the tumor has been very difficult. Even with a high index of suspicion the confirmation is difficult.

In a recent issue of the Annals of Surgery eight cases of malignant disease of the colon and rectum in patients under 20 years of age were presented. Three of these were in the pediatric age group. All of them had lymphosarcoma of the cecum and all expired rapidly in spite of surgical removal and irradiation. All had symptoms that one usually associates with large bowel obstruction. The two younger patients had intussusception which was secondary to the tumor. This should remind all of us of the importance of being sure after an intussusception is reduced by barium enema that no organic pathologic change is being overlooked.

I would like once again to thank the author for his excellent presentation of this subject and for the opportunity of discussing his paper.

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Congenital Metatarsus Varus

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The purpose of this article is to direct the attention of the obstetrician, the general practitioner and the pediatrician, as well as the orthopedic surgeon, to the entity of congenital metatarsus varus and the marked increase in its incidence, which seems to be not only apparent but an actual increase, observed during the last 30 years. To come to a realization of an actual increase in a condition which is considered congenital is a rare situation in medicine these days. It, therefore, certainly bears scrutiny with regard to terminology, etiology and the actual number of cases.

Incidence

The latest significant report was by Kite in May 1959, at which time he reported on 1,000 cases. This is the largest series and most recent report. The first case was reported by Henke in 1863. Later there were four cases reported by Helbing in 5,000 children that were seen in Hoffa's clinic in 1905. Etorre in 1921 found seven cases in 480 congenital deformities of feet in the orthopedic clinic of Milan.

These reports of isolated instances in the foreign literature are thought at this time to refer to what is now regarded as the resistant type of metatarsus varus. The article by Peabody and Muro in 1933, reporting 14 cases, was the first article in the American literature.

The influence of Kite has been felt most strongly in the recent history of the condition. He stated that he saw his first case in 1924 and his next one two years later. Thereafter, he saw approximately one to two cases each year. He noted an increase to 19 cases in 1943. In 1944 he saw 30 cases; in 1949, 106 cases; and finally, 10 years later, in 1959 he was seeing approximately 125 new cases each year.

At first there was an impression that the increase in this condition of congenital metatarsus varus coincided with a decrease in the congenital clubfoot. The facts and statistics, however, do not support this impression. Kite stated that metatarsus varus occurs more frequently in upper income families. He reported that he sees 126 cases of clubfoot in a year in the clinic and 120 cases of metatarsus varus in the same charity clinic. In his private practice he has seen 119 cases of clubfoot but a much larger series of 496 cases of metatarsus varus. He thus has a total of 691 private cases of metatarsus varus and 309 charity cases of the same condition, which leads him to the statement that metatarsus varus is four times as frequent as clubfoot in private practice.

Ordinarily, one thinks of the prevalence of clubfoot in boys by a ratio of 2 to 1, but in Kite's series there were 542 boys and 458 girls. This is not the heavy preponderance that one would expect if there is a lessening of the clubfoot condition.

Terminology

In an attempt to correlate further these strange facts of incidence, one perhaps must inspect rather carefully the terminology of this condition. In the old German literature the term used was pes adductus. This was in common use until 1912. During the last 30 to 40 years there has been an interchange in the names of metatarsus varus and metatarsus adductus, often indicating the same condition. It is thought that the older cases reported, since the incidence was less and since there was an indication that these cases were resistant to treatment, probably represent a condition which is different from the type that is increasing.

Because of the difficulty with the terminology, Blount in 1949 published an article in which he tried to interest the medical profession in using the word "skewfoot." He reported on the marked increase in this entity and suggested that this term was a much better one than several of the others that had been previously used and that after one had utilized this name, which was "catchy" much as clubfoot is a "catchy" term, then one could further break it down and differentiate between metatarsus adductovarus and adductocavovarus.

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Blount presented his paper before the American Medical Association in June 1949, and it was published the following October in the Journal of the American Medical Association. Just prior to that June meeting, however, in May 1949 at the American Orthopaedic Association Meeting in Colorado Springs, Kite reported on his first series of 400 cases containing the identifying term of metatarsus varus. Blount had published his article with regard to terminology and suggested various aspects of the treatment and care, but he had not reported on a series and did not indicate the number of patients. The weight of the large number of patients that had been seen by Kite and the fact that he is a dominant personality professionally in the care of feet tended to shift the interest and attention of the medical profession to the report by Kite. Consequently, the term of "skewfoot" never caught on and is rarely mentioned now. The popular name for this condition (which Kite called "one third of a clubfoot") has now been accepted as metatarsus varus.

It should be noted at this time that Kite reported with regard to the relative ease of treatment of this condition as opposed to the rather rare type of congenital metatarsus varus which seems extremely difficult to treat and quite resistant. In 1950 he stated that he had seen only nine patients with the resistant type of metatarsus varus out of 10,000 patients that had been seen at the Scottish-Rite Hospital.



Fig. 1.—The metatarsus varus foot is easily identified by the forefoot component of the deformity that shows an inward flare.



Fig. 2.—The position of the heel is normal. No varus component is present. This is a differential point between this type of foot and that of a clubfoot.



Fig. 3.—The adult foot may still show evidence of the inward flare of the forefoot and be a source of difficulty because of calluses and difficult shoe fitting.

Criteria for Diagnosis

The type of condition under discussion is the foot that can be seen in the accompanying photographs (figs. 1-3). There is no equinus in this foot deformity. There is also no heel deformity. For appearances it is, as Kite stated, "one third of a clubfoot." One late criterion for diagnosis is that the condition responds well to treatment. Another late criterion is that there is minimal, if any, recurrence of this condition; however, incomplete correction may occur.

Shortly after the child is born, the deformity may not be grossly apparent and, therefore, may not be noticed by either the obstetrician or pediatrician. Many times it is noted by the mother or grandmother at birth, but not thought to be of significance to the doctor. The condition usually seems to need attention at the routine six week check-up of the child. The question then is whether or not the deformity has been missed while the child was under observation in the hospital. It is now known that the condition many times is not noticeable at birth and seems to become apparent at the four to six week period. In some cases it may well be that this difference in the appearance of the foot is due to the pull of an excessively

strongly anterior tibial tendon or imbalance against an extremely weak peroneal tendon group. Most congenital deformities are present before or at birth by definition.

X-ray examination is of little or no value. In the later cases there has been some question of whether or not there is a curving of the shaft of the metatarsals. It has been shown many times, however, that this curving is more apparent than real. The first metatarsal should articulate directly in front of the first cuneiform. Often when the foot is in the varus position there is an articulation with the medial side of the first cuneiform. A differential point is the position of the navicular bone which is lateral to the head of the talus, at least as noted by the center of ossification, whereas in the clubfoot the position is on the medial side.

As part of the diagnosis one should consider the differential and of course medial torsion of the legs as well as the prominent prehensile toe in the "pigeon toe" type of foot. One should not correct or try to correct a "pigeon toe" deformity on the impression that he is treating a metatarsus varus. It should not be too difficult to differentiate between the two conditions. In fact, one should beware of trying to correct the foot that has a prehensile big toe; this condition may pass in time. The usual medial torsion of the legs is most frequently a physiological bowing of the tibia which will clear up. It should not be confused with the condition of metatarsus varus.

Rickets should not cause confusion in the differential diagnosis since it never causes a foot deformity, but in association with pigeon toeing, the effect is similar. There may be confusion in the late recurrent clubfoot. This is not likely, however, when one is familiar with the previous care of the child. Then there are the cases of spina bifida, arthrogryposis, and Friedreich's ataxia that may have associated foot deformities resembling congenital metatarsus varus. In my experience, it has been more of a problem to differentiate the conditions that I have eventually classified as metatarsus adductus or metatarsus varus of either type.

A Classification of the Forefoot Deformity

A. Metatarsus adductus (the adducted forefoot)

Many times when a child is born there is a condition of the foot which will resemble the turned-in foot, but is not a true metatarsus varus. It is the type of foot deformity that I like to think of as metatarsus adductus. This is an adduction position of the forefoot which I believe is more positional and perhaps due to the fact that the child while being carried in utero has had some pressure bearing upon the foot. It will clear up whether one treats it or not. Frequently manipulations are given and they are perfectly satisfactory as a form of treatment and perhaps will speed up the resolving of the condition although many times, if left alone, the foot will resume a normal position of its own accord. There is no varus quality to this deformity, and it is one that improves and usually is entirely cleared up in a few weeks. It is my opinion that this condition should not be included in the present group of cases of metatarsus varus.

B. Metatarsus Varus

Type I.—Resistant to Treatment (a fixed varus forefoot). This type of foot deformity has an inversion of the foot or a varus quality which the previous deformity does not have. In the newborn it is difficult to differentiate from the adductus type of foot. If one begins with manipulations of the foot and finds that there is no improvement and no change in the condition after a six week period of time, the deformity is undoubtedly that of a metatarsus varus type. If one will go through the program of treatment which is outlined herein and finds that the treatment has been of no value and that the foot is resistant to treatment, then one is dealing with an extremely rare type which was reported early in the foreign literature. This type is not on the increase, but seems to continue to occur on rare occasions. This type of deformity has a strong hereditary element to it. There are associated congenital deformities. It has a fixed valgus of the heel; surgery is frequently needed for correction of the condition; and finally, it tends to recur much as a clubfoot tends to recur.

Type II.—Amenable to Treatment (a flexible varus deformity). If the foot responds to the treatment that is outlined, then it fits into this group of which there is a marked increase in cases, as noted. There is no hereditary tendency. There are no associated congenital deformities. There is no fixed valgus of the heel. This type of deformity responds readily to treatment; and finally, there is no recurrence

of the condition if there has been adequate treatment.

Treatment

1. Mild Cases

In many instances it will be questionable as to whether or not any treatment is indicated at all except for possibly manipulations and stretching and following these measures with "swung out" shoes on weight bearing. Kite likes to start many of his patients with this type of program after the child is several weeks old, since he does not believe it is necessary to treat early in life and I would agree up to the point of possibly six to eight weeks. He thinks that if there is no improvement in one month, then one should use cast treatment. Although in many of the mild cases there will be response to manipulations of the foot, it has become my practice to avoid this therapy in all instances, and I now prefer to use a cast in all cases whether the deformity is mild or otherwise. Many times I have found that a mild condition has progressed under poor manipulation and I have lost a great deal of time by not having had a chance to put the initial cast on at a time when the correction would have been more easily obtained. It makes the manipulation much easier for the mother to perform. It then becomes a matter of holding a correction rather than striving for it.

2. Cast Treatment

It has been recommended by both Blount and Kite that casts be used for treatment. It is also my belief that a cast is the best form of treatment. Kite changes his cast weekly until the child is three months of age. Frequently it is necessary after several weeks of cast application to do no more than hold the foot in a corrected position for several more weeks. Blount's treatment is a variant of the same type of cast procedure without the detailed care in the application of the cast or frequent change of casts. It is my preference to use a single cast application which is occasionally followed by a second cast application. The cast is kept on for three to four weeks at a time. With this form of treatment it has been my experience that there is no need for a third application of a cast except in instances when the child is a "late walker." A "late walker" would be a child who does not stand until the age of 12 to 14 months or later. Standing in a walker is sufficient to prevent a recurrence. This is encouraged at eight to nine months.

3. Stretching and Manipulation of the Foot

Following the initial cast application, or if necessary, the second cast application, it is my practice to have the mother, under my guidance, learn a program of stretching and manipulation of the foot. This is carefully outlined and observed for the first few weeks following the cast removal. If the program is well explained and followed closely, it has been my experience that one or the other of the parents has been able to manipulate the foot correctly and adequately keep the correction which had been obtained with the cast. If there is any indication at all that they are losing the correction with the manipulation, this activity is vigorously doubled. It is found that the parent will renew interest in trying to keep from having the cast reapplied. There is an occasional instance when there is no cooperation on the part of the parent and the cast treatment must be reverted to and carried out in the manner of Kite. Following his cast applications he does not use the program of manipulations and stretching and this course seems to verify my finding, which is that there is minimal recurrence. Manipulations do not seem to be necessary as a follow-up to his cast treatment.

4. Weight Bearing

Some orthopedists think that children with these deformities should be placed in "swung out" shoes. It has been my observation that these children do better if they are allowed to walk barefoot or in an extremely flexible shoe. It is not necessary to use a corrective shoe.

There was an article written by Duncan in 1953 with regard to treatment that involved the use of tape. The technique of correction was excellent, but the method of use of tape which was applied by parents was not as practical as the use of the cast. It should be mentioned at this particular time also that the Dennis-Browne bar splint is not designed for treatment of this condition and has the disadvantage of overcorrection.

Complications

One should remember that even though this is a rather benign condition, there are problems of care. In treating a clubfoot one tries to hold the heel in some valgus during the course of the treatment. This should not be done in the condition of congenital metatarsus varus. One should not hold a foot in a corrective cast too long. In either instance one produces a flatfoot. This is

much more difficult to recover from than treatment of the late metatarsus varus that has had no treatment.

What of Untreated Feet?

Perhaps the best argument for the actual increase in incidence of this condition is the fact that orthopedists are not seeing the deformity in adults. Certainly we would be seeing patients with untreated metatarsus varus in our offices needing shoe corrections or complaining of calluses from the marked varus position. It is a rather disturbing thought that if many of the cases of this deformity are not now being recognized, we will be seeing it in adults in another 15 or 20 years and having to deal with the late deformity at that time.

The resistant type of metatarsus varus or the untreated metatarsus varus will probably best be approached, as time goes along, with the operative treatment that has been outlined by Herndon and Heyman as they have indicated in the operative procedure of complete capsulotomy of the proximal metatarsal heads. This operative procedure has proved its value in the treatment of the recurrent forefoot component of the clubfoot.

Etiology

There are many interesting factors that are possibly related in the etiology. The consideration of position of the fetus in utero was one of the first thoughts and this was quickly discarded since the pressure in utero is not rigid and does not explain the constant position of the deformity. This etiological factor was considered and posed by Bohm, but was soon discarded. Bohm studied embryos in relation to the etiology and finally came to the conclusion that there is an incomplete rotation as an inherent factor in some of the embryos.

Heredity has been discounted in the etiology. Peabody and Muro, when they reported on their cases, suggested a developmental defect and were convinced that a broad attachment of the anterior tibial tendon to the medial and plantar aspect of the first metatarsal was the source of difficulty. This has not been discounted, but once again does not seem to explain all cases. There have been some late questionings of environmental factors in deformities of lower extremities because of the work by Waranky and Duraiswami. Waranky thought that perhaps there was a lack of riboflavin that could explain deformities in adults since he had done some experimental work, having given riboflavin to rats between the twelfth and sixteenth days when limb buds were being formed. In the human embryo the limb buds develop at the fifth week. It is questionable whether or not a vitamin deficient factor during that period of time would be of significance or even could be a part of treatment, since many times a missed period of the mother is usually not a very convincing fact until at least the second missed period, and it is quite a jump from facts on rats to those in man.

Duraiswami's work was done with insulin injection into egg yolks. Deformities were produced by the insulin, but were prevented by injecting nicotinamide and riboflavin along with the insulin. A rather interesting fact in his work was that not only was the deformity produced, but the chickens passed the deformity on, even to the fourth generation.

In many of the series of patients that have been reported, especially by Kite, there have been questions that have been asked of the mothers of the children, and all of this questioning has been to no avail. The mothers do not appear to have a vitamin deficient diet. There was some question as to whether or not nausea was a factor; however, some of the mothers had no nausea and some had so much that they needed to have intravenous therapy. This was an inconclusive finding. The question as to whether or not x-ray exposure would be a factor soon proved to be untenable also since there was no x-ray exposure in the early months, or in fact, at any time in relationship to the incidence. Similarly, there had been no anesthetics given during the period of pregnancy which would have had an influence on the deformity developing. Another suggestion was whether or not smoking made a difference. It appeared that less than half of these mothers smoked and the national average of mothers who smoked was 48 per cent.

In other words, at the present time there is no definite answer to the increase in incidence, or to the factors that might have a bearing on the etiology.

Evaluation of Results

It has not been the purpose of this paper to discuss a large series of cases. There is a combined series of patients that has been observed during the past 10 years, both private and clinic patients. This series totals up to 140 cases. The reporting of any series of this type of condition is not a matter of reporting a large number of

good results. There is no question but that good results can be obtained with different methods of treatment. It is not, therefore, a question of technique or even of adeptness in the handling of plaster such as is true in the treatment of the congenital clubfoot. The significance and importance of this paper and of the condition itself are to bring to attention the early recognition and treatment in an attempt to avoid the large number of foot problems that may be showing up in clinics in later years.

Summary

A series of observations with regard to the history, terminology, and treatment of the condition of congenital metatarsus varus is presented primarily to bring the marked increase in the number of cases to the attention of obstetricians, general practitioners, pediatricians, and orthopedic surgeons.

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Management of the Anxious Patient in Gynecology and Obstetrics

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Experience with gynecic and obstetric complaints has shown the impact of psychic factors on the etiology of female diseases.[1-6] From earliest times it has been recognized that the physical and psychic development of the woman are inseparable components of her clinical picture. An organic disease may be prolonged, remitted, or exacerbated by her emotional responses, while a functional disorder with no discernible organic cause may be only a manifestation of deep emotional conflicts and frustrations. The endocrine system, in particular, is intimately bound to the psyche and can be influenced, consciously or unconsciously, by the emotional attitudes of the patient. At the same time, biologic changes and stress (physical disease, operations, obstetric delivery, menstruation, menopause) even when only remotely concerned with the endocrine system can initiate emotional upheavals, psychoneuroses, and, in predisposed patients, even psychoses.

A complex frequently seen in many gynecologic and obstetric patients is anxiety-tension. Some anxiety is to be expected in pregnancy, during the menopause, in times of stress, and in the presence of organic disease. In these instances of normal anxiety, an honest appraisal of the situation and friendly reassurance from the attending physician will usually suffice to restore the patient's calm and sense of security. When, however, anxiety and tension are out of proportion to the disease, or when these symptoms accompany a functional disorder not associated with organic morbidity, this state may be indicative of a deep-rooted emotional disturbance. If further examination of the patient reveals definite or possible psychosis, or severe psychoneurosis, it is best to refer her to a psychiatrist; but if the emotional distress is not associated with extreme nervous disorders, it can be effectively handled by the psychophysiologically oriented gynecologist and obstetrician.

Before initiating any treatment it is imperative that the physician acquaint himself with the character and personality of his patient. The history of her antepartum and early postpartum periods should be noted, as well as the dynamics of her psychosexual maturation. Early traumatic experiences, marital and environmental maladjustments, and past illnesses must be considered as possible contributing factors to her condition.

Good rapport with the patient, and warm and friendly understanding by the physician, without loss of objectivity, discretion and patience, are an essential part of treatment.

The first step in aiding the patient to recognize and face those conflicts which have precipitated or complicated her condition is to allay the anxiety-tension complex. Once she has improved her outlook and can evaluate her attitudes, she will be in a better position to handle her problems, either on her own or through more intensive psychotherapy. Often, simply reducing the tension is sufficient to dispel functional disturbances. With the introduction of psychotherapeutic drugs there has been a tremendous advance in the management of these states. The time involved in achieving significant improvement of anxiety has been greatly shortened, and this state of improvement can be maintained until there are signs of favorable somatic response. The disabling side effects frequently encountered with these drugs can, however, be as unpleasant as the symptoms, thus negating their therapeutic effectiveness.[7-12]

A unique contribution to psychopharmacology has been the development of chlordiazepoxide (Librium*). Chemically, Librium is 7-chloro-2-methylamino-5-phenyl-3H-1, 4-benzodiazepine 4-oxide hydrochloride. Its high degree of efficacy, coupled with a remarkable record of safety has established it as a valuable ataractic agent in the treatment of certain medical and psychiatric disorders.[13-18] Prompted by its successful use in various other areas of medicine, I set out to evaluate its effectiveness in gynecologic and obstetric patients presenting functional and organic conditions with overtones of severe anxiety-tension.

Methods and Materials

One hundred and two gynecologic and obstetric patients with and without discernible organic disorders were treated. All exhibited tension and anxiety beyond that normally seen in such conditions. To facilitate evaluation they were arbitrarily divided into four categories according to their predominant symptoms: obstetric, neuroendocrinologic, psychophysiologic, and psychoneurotic. There was, of course, some overlapping, a number of symptoms, such as environmental maladjustment, compulsive eating, phobic reactions, nymphomania, and functional complaints, being common to two or more of the categories.

*Trademark, Hoffman-La Roche Inc., Nutley, N. J.

Obstetrics.—This category included 22 patients with emotional tension due to pregnancy, nine with postpartum neuroses, and four with threatened abortion or postabortion neuroses with guilt. The average age was 27 years, the youngest being 18 and the oldest 40 years.

The most frequent symptoms in the pregnant women were fear of delivery, particularly in primiparas and in multiparas who had experienced accidents in previous deliveries, and fear of abortion because of previous miscarriages. Maladjustment to married life and motherhood was also present in a number of cases, and two refugee patients were experiencing temporary maladjustments to change in environment. Some exhibited real or imagined fears concerning infidelity of their husbands, or the added financial strain of a child. A few had become compulsive eaters, although one patient in her eighth month of confinement insisted on dieting against my advice in an effort to "retain her figure."

Neuroendocrinologic Syndromes.—In this category were included 15 patients with premenstrual tension and 10 with menopause and postmenopausal syndrome, including surgical menopause. The average age in the menstrual group was 33, and in the menopausal group 43 years.

All the patients with premenstrual tension experienced accompanying headaches, leg cramps, pelvic aches, or edema, alone or in combination. There were also one instance of depression and one of anxiety neurosis due to fear of recurrent phlebitis. One patient had undergone sterilization six years earlier. It is pertinent to mention that tubal ligations are among the most common causative factors in long-standing anxiety neurosis and psychosexual derangements associated with feelings of guilt. In my experience these problems occurred in almost every instance where this surgical procedure was carried out.

Aside from severe tension, many women in the menopausal group complained of hot flashes and functional disturbances. There were two instances of accompanying psychosexual neurosis and one of obsessional neurosis, the latter a woman in her early fifties obsessed by the desire to have a child.

Psychophysiologic Syndromes.—In this category were placed patients with functional disorders but no demonstrable organic diseases, including four women (average age 29 years) with long-standing sterility and three (average age 28 years) with miscellaneous somatic complaints.

Also included here were those with chronic infections not amenable to specific chemotherapy, but exhibiting definite relation to the emotional state of the patient, specifically, three patients (average age 39 years) with trichomonal vaginitis.

All the patients with sterility problems had normal ovulation and no evidence of mechanical tubal obstruction. Their husbands also showed normal fertility. All were anxious to have a child, although one woman was fearful that the presence of minor multiple pathologic changes of the uterus would interfere with pregnancy. In the miscellaneous group there was one patient with periodic migraine headache and mild cardiac arrhythmia due to bronchial asthma of nervous origin, and two experienced menstrual irregularities due to phobias and emotional strain.

Psychoneurotic Syndromes.—In this last category were placed those patients with personality disorders stemming primarily from emotional tension and stress. These included 23 patients with moderate to severe depressive reaction, eight with anxiety reactions associated with organic diseases, and one with severe depressive reaction. The average age in these patients was 39, the youngest being 15 and the oldest 70 years.

In the simple anxiety-tension group, the most frequently observed factor was psychosexual maladjustment. These patients manifested severe pregnancy phobias, fear of and disappointment in their husbands, and inability to cope with the psychosexual problems of their husbands. A few had become compulsive eaters with the added problems of obesity and frustration from unattractiveness. The other patients in this group showed maladjustment to their environment. They were unable to handle financial difficulties, or cope with family problems. One patient was reactive to her past experiences in a concentration camp and could not adjust to life in this country. Of the eight patients with tension associated with organic diseases, three were mildly depressed because of previous surgical procedures. In one a cancer phobia had developed, and in a second, nymphomania with general near-exhaustion. The remaining patients had various gynecologic problems, adenomas, fibromas, and metabolic disturbances, often with menstrual irregularities. There was also one patient with severe depressive neurosis aggravated by osteoarthritis of both extremities, as well as involvement in divorce proceedings. Many patients also manifested obsessive-compulsive habits.

The schedules for Librium dosage were varied. The most frequently employed were 10 mg. three times a day when the symptoms were moderate and 10 mg. four times daily when they were severe. One patient with menstrual irregularities and two with psychoneuroses received 10 mg. every four hours, and three patients with psychoneuroses were instructed to take 10 mg. before going to bed in addition to the usual dosage three times a day. In all but the patients with premenstrual tension, therapy was maintained without interruption for from eight days to two months. Those with premenstrual tension took Librium for five to six days prior to and throughout the menstrual period. In pregnant women therapy was often continued up to term, but was discontinued once labor had begun. Librium was also administered to the husband of one sterile patient in an attempt to improve their emotional relationship.

Fourteen of the patients with premenstrual tension received a diuretic concomitantly with the Librium because of edema, and two patients with sterility problems took ½ grain of thyroid daily. Other concomitant therapy was limited to cortisone in one patient with recalcitrant vaginitis, steroid-complex medication in one with surgical menopause, antianemic and thyroid therapy in one with psychoneurosis, and antiarthritic medication in the one patient with depression and osteoarthritis.

Results

Obstetrics.—All the patients, except one in whom follow-up was not possible, showed marked reduction of tension and improved attitudes. The pregnant women became more cooperative, completely or almost completely losing their fears of delivery and abortion, and developing a better understanding of the possible surgical procedures that might be necessary at delivery. All the pregnancies continued uneventfully, and none of the threatened abortions materialized. In patients with postpartum neuroses, there was a return of confidence and self sufficiency, reflected in their ability to carry out their maternal duties efficiently. Compulsive eaters followed their diets without need of appetite depressants; feelings of guilt and inadequacy were allayed. In two instances, occasional weariness and drowsiness followed ingestion of Librium; these were transitory and at no time interfered with the patients' normal activities.

Neuroendocrinologic Syndromes.—The patients with premenstrual tension obtained consist-

ently excellent results with complete recession of their tension and somatic complaints. In all but one patient with menopausal problems, improvement was obtained without need of hormone therapy. There was a decrease in obsessive and compulsive acts, and those exhibiting nymphomania behaved more normally. In one of these patients there was some somatic improvement, but the problems was considered psychiatric and impossible to remedy completely except through intensive psychotherapy. One patient who had previously been under Trilafon therapy experienced slight dryness of mouth, but also commented, "This medicine [Librium] is far superior for my case."

PSYCHOPHYSIOLOGIC SYNDROMES. — The results in patients with this form of sterility problem were good to excellent. Two patients became pregnant within five weeks of initiating therapy. The remaining two patients have been under treatment for only three weeks, but they have shown remarkable improvement in their emotional status. The three patients with recalcitrant vaginitis obtained excellent amelioration of their condition, clinically and emotionally. In the miscellaneous group there was remission of all complaints. The periodic migraines ceased and normal menstrual cycles appeared to commence. One patient experienced slight, transient drowsiness.

PSYCHONEUROTIC SYNDROMES.—One patient with simple anxiety-tension was lost to follow-up, but all the others showed marked improvement. They felt less harassed and developed greater personal insight and self control. Those referred for psychiatric help proved cooperative and amenable to psychotherapy. Where family and environmental problems were present, the patients showed better understanding of their situations and handled them with increased calmness and efficiency. Compulsive eaters succeeded in dieting without aid of anorectic medication, and phobic patients lost their fears. Those with tensions due to organic diseases and postoperative neuroses improved emotionally, becoming cheerful but not agitated. Although gynecologic improvement was not always present, they were able to accept the need for possible surgical measures calmly. Patients with psychosexual problems characterized by nymphomania experienced decreased libido and behaved more normally. The one patient with depressive neurosis obtained great release from her tension with increasing optimism. Three patients experienced occasional weariness and drowsiness, but these were transient and there was no need to discontinue therapy.

It will be noticed that for three patients in this group 60 mg. per day, about twice the recommended daily intake, was prescribed because the severity of symptoms in these patients warranted the higher doses. Only one woman had some drowsiness, which disappeared when the dosage was reduced to 40 mg. per day.

The total results can be summarized as 85 excellent responses (83 per cent), 13 good (13

Results of Administration of Chlordiazepoxide (Librium) by Specific Diagnostic Categories in 102 Patients

Diagnoses	Number of Patients	Response				Side Effects
		Excellent	Good	Fair	No Follow-up	
OBSTETRICS						
Emotional tension due to pregnancy	22	21			1	2
Postpartum neuroses	9	8	1			
Abortion and threatened abortion	4	3	1			
NEUROENDOCRINOLOGIC						
Premenstrual tension	15	15				
Menopause and postmenopause syndromes	10	8	1	1		2
PSYCHOPHYSIOLOGIC						
Sterility	4	2	2			
Vaginitis (recalcitrant)	3	3				1
Miscellaneous*	3	2	1			
PSYCHONEUROTIC						
Anxiety reaction	23	17	4	1	1	3
Anxiety reaction associated with organic disease	8	5	3			
Depressive neurosis	1	1				
Totals	102	85 (83%)	13 (13%)	2 (2%)	2 (2%)	8 (8%)

*One migraine headache, two menstrual irregularities.

per cent), two fair (2 per cent) and two without follow-up (2 per cent). Eight patients had side effects (8 per cent), seven experiencing drowsiness and weakness and one complaining of a metallic taste in the mouth. These reactions were mild and transient, usually disappearing after a few days of therapy or with adjustment of the dosage schedule. The results for the specific diagnostic categories are summarized in the accompanying table.

Discussion

As can be seen from the variety of symptoms presented in this study, there are almost no limits to the gynecic and obstetric complaints that may develop or become aggravated by the emotional state of the patient. Moreover, it can be seen that the attending physician can, in many instances, manage these emotional factors without referring the patient for psychotherapy. It is necessary, however, to distinguish between the temporary states of anxiety and depression that fall within the limits of normal human behavior, and acute psychoneurosis and psychosis. With the refinement of diagnosis, the physician will become aware of those patients whose situations call for intense psychotherapy to assure complete cure, as distinct from those whose somatic complaints may be treated in the light of his own field of specialization.

No somatic complaint should be dismissed as psychogenic without a thorough examination for possible organic causation, however remote. Conversely, overconcern with organic origins where none are demonstrable will not lead to elimination of the symptoms and may only obscure their true nature. The patient must be treated as an integrated organism, with close interaction of physical and psychic factors, each influencing the other.

In the current study all the patients showed acute anxiety requiring quick and effective management before amelioration of their somatic complaints could be effected. In almost all instances their response to Librium was remarkable improvement in emotional status, with 83 per cent obtaining excellent results. Those with psychiatric problems became more amenable to psychotherapy; their psychophysiologic complaints disappeared, and there was a general reduction of tension, synchronous with increasing personal insight. The few side effects observed were mild and transitory and did not interfere with the patients' normal activities or maintenance of medication. Those ingesting Librium for extended periods showed no signs of dependence or habituation.

Thus, when compared with the older psychotherapeutic drugs and judged by the same standards, namely, effectiveness, speed of action, toxicity, and habituation, Librium appears to be superior for the management of nonpsychiatric patients with somatic complaints related to acute emotional distress.

Summary

Librium was administered to 102 patients with gynecic and obstetric complaints complicated by anxiety-tension complexes. Their symptoms were classified as predominantly obstetric (35 patients), neuroendocrinologic (25 patients), psychophysiologic (10 patients) and psychoneurotic (32 patients).

Librium was administered alone or concomitant with other medication when there were organic disorders. The dosage schedules were adjusted to the specific needs of the patient and varied from 10 mg. twice a day to 10 mg. every four hours. The duration of therapy was from eight days to two months.

Eighty-five patients had excellent results, 13 good results, and two fair results; two were lost to follow-up. Side effects were observed in eight patients: seven women became weary or drowsy and one experienced a metallic taste in her mouth. These were transient and usually disappeared after a few days or with reduction of dosage. Some patients commented on their preference for Librium over previous medication.

Librium appears to be superior to the more commonly used psychotherapeutic drugs for the management of nonpsychiatric patients in need of relief from emotional distress. Its selective use as a calming agent is recommended in gynecology and obstetrics.

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ABSTRACTS

Ventricular Aneurysm. By Richard G. Connar, M.D., and Leffie M. Carlton, Jr., M.D. South. M. J. 53:783-791 (June) 1960.

With more patients having had a severe myocardial infarction with subsequent recovery, the rare lesion of ventricular aneurysm may be encountered more often in future. With the possibility that surgery may decrease the mortality it behooves physicians to diagnose this lesion before death. Also, with a better knowledge of the natural course of the disease, they will be able to select patients for operation more critically. Cardiac aneurysms may be congenital or acquired. The commonest type is that following myocardial infarction, and it invariably involves the wall of the left ventricle. During the last three years the authors have seen seven patients with postinfarction aneurysm of the left ventricle, three of whom were subjected to operation. The seven cases are described.

The various factors facilitating the formation of ventricular aneurysm are discussed. There are no typical electrocardiographic changes diagnostic of ventricular aneurysm, but the continual presence of a pattern of recent myocardial infarction should arouse suspicion. Roentgen examination is the only reliable method of establishing an ante mortem diagnosis. Angiocardiography is helpful in verifying the diagnosis. Direct cardioangiography may be useful in selecting patients for operation. The prognosis for patients with ventricular aneurysm is poorer than in myocardial infarction alone. Death is caused by intractable cardiac failure from paradox, embolization or subsequent infarction. Rupture of the aneurysm rarely occurs. Surgery may be life-saving in that paradox and/or source of embolization may be eliminated. Various technical aspects of the operative procedure are discussed. Placing mattress sutures through the pericardium and aneurysm wall, and ligation prior to the application of a noncrushing clamp constitute the procedure of choice in the opinion of the authors. The use of temporary cardiopulmonary bypass may prove to be superior. Asymptomatic patients should not be subjected to operation.

Acute Noncalcareous Cholecystitis with Associated Mesenteric Adenitis in a Child. By Banning G. Lary, M.D., and Karen Howard, M.D. A. M. A. Arch. Surg. 79:605-606 (Oct.) 1959.

In children cholecystitis is an uncommon disease. The case here reported is of interest in that acute noncalcareous cholecystitis in a girl nine years of age was associated with a mesenteric adenitis. It would indicate that even though pathologic change in the form of mesenteric adenitis is present when the appendix is normal, the gallbladder should be palpated for abnormality.

Acute Hemolytic Anemia and Agranulocytosis Following Intravenous Administration of Toluidine Blue. By Antonio Marquez, M.D., and M. Todd, M.D. Am. Pract. & Digest Treat. 10:1548-1550 (Sept.) 1959.

The management of acute episodes of bleeding may be a simple matter, and may require careful study in an effort to determine the cause. If anticoagulants are demonstrated in the circulating blood, the use of toluidine blue may be considered. The case here reported emphasizes that one should be certain of the indications for its use before a potentially toxic substance is employed. In this case acute hemolytic anemia and agranulocytosis are reported as complications of toluidine blue therapy. Their coexistence with this therapy has not previously been described in the literature. The modes of action of toluidine blue and its potential harmful effects are discussed. It is concluded that the presence of a heparin-like substance warrants the use of protamine sulfate rather than toluidine blue. The diagnostic approach to a patient with a hemorrhagic disorder is discussed.

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Samuel Carnes Harvard, M.D.

President 1961-1962

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Samuel Carnes Harvard, M.D., President

For more than a quarter of a century Dr. Samuel Carnes Harvard, the incoming President of the Florida Medical Association, has engaged in the general practice of medicine in Brooksville. Born at Arabi, Ga., on Jan. 6, 1902, Dr. Harvard was the son of the late Dr. Virgil O. Harvard, a local physician, and Mildred Hunter Harvard. He received his academic and professional schooling in his native state. Upon graduation from Emory University Academy at Oxford, he attended Emory University in Atlanta, where he was awarded the degree of Bachelor of Arts in June 1922. For his medical training he entered Emory University School of Medicine and received the degree of Doctor of Medicine there in June 1930. Following a one year internship at Grady Memorial Hospital in Atlanta, he served for 18 months as a resident at its Steiner Clinic.

In January 1933 Dr. Harvard came to Florida and located in Brooksville. During the 28 years he has served this progressive and appreciative community, he has had a leading role in the building of the present modern Hernando County Hospital and has served for years as a member of its staff and as resident surgeon. He has also served as County Physician and is the Atlantic Coast Line Railroad physician. From the beginning he has been a leader in the civic, social and religious life of the community. A member of the Brooksville Methodist Church, he has served for four years as chairman of its board of stewards. In 1936 he was president of the Brooksville Kiwanis Club, and his activities throughout the years in furthering the work of this organization and in rendering faithful and untiring service to the community at large were fittingly recognized by the club in October 1958. At a special banquet honoring the two veteran physicians of the county, he was presented with an engraved plaque lauding his 25 years of service and given a standing ovation by some 200 men and women of the community and county who had come to pay tribute to him.

Dr. Harvard is a member of the Pasco-Hernando-Citrus County Medical Society and has repeatedly served it in an official capacity. Several times he has held the office of vice president and he has served as president for several terms. For a number of years he has represented his county society as a delegate to the House of Delegates of the Florida Medical Association.

In the Florida Medical Association Dr. Harvard has long been active and has held posts of high responsibility in recent years. In 1957 he was Chairman of the Council. The following year he served as First Vice President and was Chair-

man of the Committee on Medical Economics. In 1959 he became a member of the Board of Governors. Also at the state level, he has been a member of the State Board of Medical Examiners since 1958 and he was appointed by Gov. LeRoy Collins in 1959 to membership on the Florida Citizens Medical Committee on Health.

A member of the Florida Obstetric and Gynecologic Society, Dr. Harvard has at various times served on several special committees appointed by the president and was himself president of this organization in 1957. He has through the years held membership in the American Medical Association and the Southern Medical Association.

Dr. Harvard and Mrs. Harvard, the former Jimmie Brown of Columbus, Ga., have a 19 year old daughter, Jane Hunter Harvard.

"To Care For The Patient"

The Eighty-Seventh Annual Meeting of the Florida Medical Association will have just concluded as this appears in print. Based on the trend of the past few years, it is safe to state that the largest attendance, the most exhibitors, the best-yet scientific program and the usual intangible benefits from social contacts will have characterized the meeting. Since about one half of the physicians in Florida now limit their practice to one of the specialties, increasing interest and attendance will have been shown in the meetings of the specialty groups. The action of the Board of Governors in permitting the distinguished out-of-state guest speakers, invited by the specialty groups, to address the Association in the third Scientific Assembly is to be commended.

The meeting will have been a success, however, only if all aspects were ultimately concerned with improving the care of the patient. This is the obvious and only intent of the Scientific Assemblies, but the deliberations of the House of Delegates may seem to lose sight of this goal as they involve matters of economics, governmental control, regulation of laboratories and the like. These are knotty problems and not easy of solution, but the proper answers will never be reached if the economic welfare of the doctors is the criterion. It is to be hoped that each decision of the House of Delegates was arrived at after consideration of its ultimate effect on patient care, and that this objective was so obvious that even the lay press could report that our deliberations were entirely centered on improving the lot of the patient.

Our centuries-old reputation for selflessness has become tarnished; in modern jargon the doctor's "image" is changing to that of a tradesman characterized by selfishness. Only by our corporate as well as by our individual actions can we correct this impression. Let it be evident to all that we are continuing to heed Dr. Francis Peabody's maxim: "The secret in the care of the patient is to care for the patient."

J. M. P.

Our Editor Emeritus

Perhaps no one in the 87 year history of the Florida Medical Association has contributed as much to our organization and to the advancement of Medicine in the State of Florida as the quiet, modest, unassuming gentleman who, on May 28, 1961, became Editor Emeritus of The Journal of the Florida Medical Association. In relinquishing the active editorship of The Journal at this time, Dr. Shaler Richardson concludes a tenure of office which extended over a period of 33 years—years of able, progressive and dynamic direction which established our state journal as a much emulated example in the field of medical publications. Certainly it is fitting that he should have been the second recipient of the Award of Merit—and certainly, if all future recipients of this honor are measured against the service record of the two titanic figures who have to date received it, they will be few indeed.

In addition to his official position as Editor of The Journal since 1925—except for the war years when he served as President-Elect in 1944 and 1945 and assumed the Presidency of the Association in 1946—Dr. Richardson has ever been available as an informal, sagacious advisor to all young physicians and especially to the many officers and committee chairmen whom he has seen come and go throughout the years.

It is with deep regret and nostalgic sadness that the Association recognizes, with Dr. Richardson's retirement from active service on The Journal, the end of an era in Florida Medicine and Journalism—an era which was productive of many healthy expressions of principle, of ethics, of hard,

cooperative effort, and of individualism. Surely this was an era of development of which its strong proponents, like Dr. Richardson, may well be proud. Certainly it will be long before images comparable to theirs will appear on the face of Florida Medicine.

To our first and only Editor Emeritus we accord the highest respect—the greatest affection—and the eternal devotion which he will ever command as the Association's most unselfish, dedicated and tireless servant. It will be long, indeed, before another will contribute as much; and we are grateful that the advice—the judgment—and the wisdom of this gallant gentleman will continue to be ours for the asking.

We will be calling on you, Chief.

J. W. A.

Self-Policing of Blood Banks

Of all the procedures done by the laboratory technician, those that pertain to the preparation of blood for transfusion are most apt to be lethal when done carelessly. Inadequate cleansing of the donor's arm may result in a contaminated unit; failure to perform duplicate tests may result in improper labeling; adherence to outmoded cross-match techniques has resulted in hemolytic reactions. Since there are many steps from donor to recipient, there are many opportunities for slip-ups.

The mortality from the administration of blood transfusions is unknown. Many of the deaths have been preventable. In a recent court decision in Florida, $150,000 was awarded to the plaintiff for such a preventable death. Aside from those who have died, a much larger number of patients have been made seriously ill and their hospital stay prolonged from the receipt of unmeticulously prepared blood.

Recognition of the preventability of blood transfusion mishaps has led to the inauguration of an increasingly vigorous self-policing campaign by blood bank organizations. A pamphlet, Standards for a Blood Transfusion Service, has become the guidepost for blood bank inspections. Each Florida blood bank member of the state association is subjected to an annual increasingly rigid inspection. Those banks that adhere to good practices as outlined in the Standards are issued a certificate of accreditation. Certificates are withheld where good techniques are not practiced or where technicians have grown slovenly in their habits.

The ultimate aim of this self-policing inspection program is to improve the welfare of patients. It behooves Florida physicians, through their hospital staffs, to insist that all blood bank technicians be thoroughly familiar with the Standards for a Blood Transfusion Service. Physicians must show these and other ancillary medical personnel that perfection in technique is essential to proper medical care.

J. J. L.

Pelvic Pain of Obscure Origin

Many women complaining of pelvic pain leave the physician's office with a feeling that they have been inadequately treated. Many resent, and rightly so, the physician's statements or implication that they are "neurotic." Most of us can easily palpate the large ovarian cyst and the myoma. We can relieve the uncertainty of such a patient as to the cause of her pain and we can promise her relief. If, on the other hand, the pelvic organs are apparently normal, we often dismiss the patient abruptly and say, "There's nothing wrong with you." It is true that in many instances pelvic pain is of psychosomatic origin, but we must remember that the patient may have both psychosomatic and organic disease.

Unfortunately, we often fail to find the organic disease because of haste or lack of experience. A complete gynecologic history may reveal information that leads us to a diagnosis. Acquired dysmenorrhea, for instance, usually indicates organic disease, including endometriosis, adenomyosis, and retroversion of the uterus. If, as a result of childbearing, a woman has acquired both dysmenorrhea and a retroverted uterus, the physician's first thought should be a trial period with the pessary.

Repeat pelvic examinations, especially immediately after menses, may reveal the tiny nodules of early endometriosis that were overlooked on the first examination. A minor finding may cause considerable discomfort. Examples are the minimal tenderness and enlargement of all the internal genitalia in cases of chronic pelvic vascular congestion and the ovary that is immobile due to old pelvic inflammatory disease or endometriosis. The congestion usually responds to testoster-

one or a diuretic. The patient with either condition should not be denied surgical relief if medication fails, just because she has a "minor condition."

Finally, if we are unable to make a diagnosis, we can truthfully tell the patient that we have seen these symptoms subside in a few weeks or months without treatment.

WILLIAM M. COLMER JR., M.D.
PENSACOLA

Melbourne High School Student Takes Top Science Fair Award Second Time

A Melbourne High School senior accomplished what no one else has before in the upper division of the State Science Fair. Chris George Cherniak of Eau Gallie won the Florida Medical Association's senior award for medical aptitude for the second straight year.

Young Cherniak's feat was all the more impressive because it was done with two different exhibits which were selected by two entirely different judging committees. For the outstanding effort displayed in both his knowledge and his exhibit, which was entitled "Development and Use of Tissue Culture of Functioning Single Neurons," Cherniak received a 100 dollar United States Savings Bond and a handsome, hand-lettered citation.

The Association's fifth annual awards for medical aptitude were presented during the 1961 State Science Fair, held April 6-8 at Florida Southern College in Lakeland. Fifty out of a total of 317 exhibits were considered for the awards by a skilled panel of medical judges composed of Drs. John C. Moore Jr. and Frank H. Deland of Lakeland, Edward C. Burns Jr. of Lake Wales and Arnold J. Spanjers of Winter Haven. Each of the exhibits judged received a certificate of recognition from the Association.

The winner of the first place award in the junior division was Emil Frank Powella of St. Joseph's School, Lakeland. His prize was a 50 dollar United States Savings Bond and a hand-



Dr. John E. Daughtrey of Lakeland, president of the Polk County Medical Association, hands certificates to winners of Florida Medical Association first place senior and junior awards in 1961 State Science Fair, Chris Cherniak of Eau Gallie (center) and Emil Powella of Lakeland (right).

lettered citation. The title of his exhibit was "A Test for Anti-Cancer Activity."

As it has for the past several years, the Womans' Auxiliary to the Association furnished much appreciated assistance to the project by providing four honorable mention awards of 25 dollar United States Savings Bonds and hand-lettered certificates. Three of these runner-up awards were presented in the senior division and one in the junior.

The senior honorable mention winners and their exhibits were Judyth Anne Vary of Manatee High School, Bradenton, "Research on the Chemotherapeutic Action of AET and MEA plus 2M-DHTP on Irradiated Carcinomatous and Normal Tissues in White Mice;" Arthur Clifford Aycock of Haines City High School, "Cytopathology of a Tumor Infected with Influenza Virus PR8;" and Charles William Ragsdale of Leon High School, Tallahassee, "Electroencephalography."

Donald A. Shreve of Wilson Junior High School, Tampa, was the junior honorable mention winner with his exhibit entitled "Radiation—Abnormalities Caused by Ionizing Radiation." Young Shreve won the top junior medical award in the 1960 State Science Fair held in Melbourne.

The coveted first place medical prizes were presented to the winners by Dr. John S. Daughtrey of Lakeland, president of the Polk County Medical Association, in the unavoidable absence of President Leo M. Wachtel, who had to preside over a meeting of the Board of Governors being held in Jacksonville the same day. Dr. Daughtrey supervised all local arrangements for the project. The Woman's Auxiliary awards were formally presented by Mrs. John M. Butcher of Sarasota, president of the state group.

American Medical Association First Research Forum to Highlight Scientific Program of Annual Meeting

The first Multiple Discipline Research Forum of the American Medical Association will be one of the main features of its 110th annual meeting in New York City, June 25-30, 1961.

The forum, embracing 15 branches of medicine, will include reviews of past research, brief reports on new research, and discussions of future trends in research.

The first two days of the forum will be taken up with reviews of the contributions of basic and clinical science to medicine and medical practice and panel discussions on future trends in research in anatomy, biochemistry, physiology, biophysics, pathology, microbiology, pharmacology, genetics, obstetrics-gynecology, pediatrics, neurology, psychiatry, internal medicine, surgery, and nutrition, including the possible relationship to unsolved clinical problems.

The presentation of original fundamental research by 60 young investigators in a variety of disciplines will begin at 4 p.m. Wednesday and continue through Thursday. Brief discussion periods are scheduled for these five-minute reports.

The Goldberger Lecture will be delivered Tuesday as a feature of the research forum.

National Clinical Meeting Of Obstetricians and Gynecologists Held at Miami Beach

The Tenth Anniversary Clinical Meeting of The American College of Obstetricians and Gynecologists was held in Miami Beach on April 23-28, 1961. More than 2,000 physicians from the United States and 22 foreign countries were in attendance, and the College voted to return to the same setting for the 1964 Clinical Meeting. Dr. Ralph W. Jack was chairman of the committee on local arrangements.

Among the highlights of the scientific program were the observations of Dr. Roberto Caldeyro-Barcia of Montevideo, Uruguay. After cannulating breast ducts following delivery, he gave Pitocin, producing an increase in milk secretion as recorded by a manometer. From this result he postulated a direct effect of Pitocin on milk secretion in the breast in the postdelivery period.

Asymptomatic bacilluria and its influence upon premature delivery and perinatal death were discussed by Dr. Edward H. Kass of Boston. In his opinion, data not yet complete indicate that as high as 27 per cent of all instances of unexplained premature labor may be associated with undiagnosed infections of the urinary tract. The possibility of bacterial endotoxins influencing uterine muscular irritability was presented. It was his suggestion that the physician be not so quick to catheterize and that the treatment of cystitis and pyelitis be intensive and adequate intially rather than casual as is frequently the practice. The value of a bacterial culture with a colony

count as an index of recovery was stressed, with a count greater than 100,000 per cubic centimeter indicating a need for further therapy.

Studies on the use of metronidazole (Flagyl) in the treatment of vaginal trichomoniasis refractory to the usual methods of treatment were presented by Claudius P. Jones, a medical technician, Dr. Roy T. Parker and the staff of Duke University School of Medicine. They reported excellent results in 100 cases. This medication is expected to be available for clinical use by mid-summer 1961.

JEAN B. WILLIAMS JR., M.D.
JACKSONVILLE

American Academy of General Practice Holds Scientific Assembly in Miami Beach

The Florida Academy of General Practice had the honor of being host to the American Academy of General Practice at its Thirteenth Annual Scientific Assembly held April 17-20, 1961, at Miami Beach. The excellent setting for the meeting was symbolized by a beautiful painting, "Breath of Florida" by B. Backus, which was a gift of the Florida Academy and the Dade County Academy to the national organization for its headquarters building in Kansas City.

Present to welcome the nearly 3,000 general practitioners who attended this meeting were Dr. Willard E. Manry Jr., of Lake Wales, acting president of the Florida Academy of General Practice, and Dr. Leo M. Wachtel, of Jacksonville, president of the Florida Medical Association, who is also a past president of the Florida Academy. In addition to the 2,725 physicians who registered, there were 1,090 technical exhibitors, 325 scientific exhibitors, and 285 others who registered for the meeting. President John G. Walsh, of Sacramento, Calif., was succeeded in office by the fourteenth president, Dr. Floyd C. Bratt, of Rochester, N. Y.

An outstanding feature of the program was a panel discussion on "Economics of Medicine Today and Tomorrow." Representatives of medicine, labor, agriculture, insurance, and industry were all present to exchange views on caring for the health of Americans. The moderator was Dr. John S. De Tar, of Milan, Mich., who in the past had served as vice speaker, speaker, and president of the American Academy of General Practice. The panel was composed of Dr. E. Vincent Askey, of Los Angeles, president of the American Medical Association; Mr. Leonard Woodcock, vice president of the CIO Division of the American Federation of Labor, substituting for Mr. Walter P. Reuther; Mr. Roger Fleming, Washington, D. C., secretary-treasurer of the American Farm Bureau Federation and director of the Washington office; Mr. R. Conrad Cooper of Pittsburgh, Pa., executive vice president of personnel service of the United States Steel Corporation; and Mr. Howard Hassard, of San Francisco, legal counsel of the National Association of Blue Shield Plans and counsel and executive director of the California Medical Association. Mr. Fleming thrilled the audience with his strong case against socialized medicine.

Mr. Mac F. Cahal, publisher of GP magazine and executive director of the American Academy of General Practice from its inception, has given strong leadership. During 1960 there was a net membership gain of 962 so that on Dec. 31, 1960 the membership totaled 26,724.

The Headquarters Building Fund was oversubscribed, it was announced. A ceremony was held at a luncheon, at which time the mortgage was burned.

Ross Laboratories, of Columbus, Ohio, has for 10 years donated two cash awards of $1,000 each for the two best articles in GP during the year. Dr. Robert A. Major of San Francisco, Calif., and Dr. Jerome T. Nolan Jr., of Exeter, N. H., were the winners this year.

Mead Johnson & Company announced 20 cash awards to qualified interns or residents who will begin or continue general practice residencies in July. Each one will receive $1,000. This award program is now in its tenth year. Two of these residencies will be served in Florida. Dr. Franklin P. Holman, presently interning at St. Vincent's Hospital in Jacksonville, will continue his residency training there. Dr. Arthur W. Sweat, presently interning at Salt Lake County General Hospital in Salt Lake City, Utah, will take his residency training at Mound Park Hospital in St. Petersburg.

General practitioners should plan now to attend the next Scientific Assembly, which will be held April 9-12, 1962, in Las Vegas, Nev.

Dr. Franklin J. Evans, of Coral Gables, was chairman of the Local Arrangements Committee. Mrs. Walter J. Glenn Jr., of Fort Lauderdale, headed the Ladies' Entertainment Committee.

L. PAUL FOSTER, M.D.
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Organized obstructionists! Doctors are always in opposition, never constructive, forever attempting to block progress, and interested only in matters which may have material benefit to themselves.

Sound familiar? It is no disclosure to say that aspersions of this nature are continuously being cast at the medical profession in monotonous repetition and with parrot-like originality. It may also be advanced that this type of reasoning is by no means reserved for those who choose to select doctors for their particular targets. It is normal to label those who differ with our views as reactionary, capable only of negative thinking. It is the rare individual who will concede great wisdom to expressions, positions or actions on the part of those with whom he does not agree.

It comes as no surprise, then, that the same reflections, from the same sources and with similar logic, are frequently cast at the doctor-sponsored plan for prepayment of expenses due to illness. No less is Blue Shield accused of stagnation, of being behind the times and of being operated primarily for the benefit of the medical profession, with little consideration for the subscriber who pays the bill.

Shall we examine the record? Space permits recounting but a few examples. On the national level, in full coordination and in complete cooperation with Blue Cross, Blue Shield evolved and implemented the largest and most comprehensive voluntary nonprofit health benefits project ever attempted, the Service Benefit Plan for federal employees. Blue Shield Plans throughout the country endorsed and tangibly supported the National Association of Blue Shield Plans in its negotiations with the United States Civil Service Commission. The various local Plans evidenced their solidarity by agreeing to provide for federal employees service benefits suitable to the particular area, or to provide benefits under a uniform indemnity schedule.

On the local level Blue Shield accepted the challenge to provide service benefits to federal employees receiving professional services in Florida, at the income levels specified by the Civil Service Commission for the high and low options available to those federal employees selecting the

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One or two tablets t.i.d. Available in tablets of 200 mg. each. Athemol is easily tolerated, and can be administered safely over a prolonged period.

REFERENCES:
(1) Buck, R. C.: Minerals of Normal and Arteriosclerotic Aortas, Arch. Path., 51, 1951. (2) N. Ressler, et al.: Relation of Serum Stability to the Development of Arteriosclerosis, Amer. J. Clin. Path. vol. 24, 1954. (3) S. D. Jacobson, M.D., Wayne County General Hospital, Eloise, Michigan. To be published. (4) Prof. V. Patzelt, Untersuchungen uber die Veranderunger der Bluteiweisz-Korper mit Mag. 3, 7-dimethyl-xanthine oleate, Klin. Med. 5, 11, 1956. (5) Dr. J. Skursky, Wiener Med. Wochenschrift, 1953, Nr 46, S. 886-887. (6) Eduard Keeser, M.D. and K. F. Benitz, M. D., Med. Klin. 1953 Nr. 15.



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Detroit, Michigan

Service Benefit Plan. Using a relative value scale a schedule of benefits was developed for each option. Participating physicians throughout the state have joined with their Blue Shield Plan to demonstrate the efficacy of the service benefit principle.

In recent months new local Plan Blue Shield contracts have been developed and made available to the public. Most notable among these is the type "K" which provides increased and added coverage, with more liberal benefits based on a relative value schedule applied to realistic income levels. The type "H" contract, similar benefit-wise to the "K", is available to former federal employees wishing to convert to a direct pay status. Most recent to appear is the type "N" contract available only to national groups and with benefit payments solely on an indemnity basis. In addition, most local Blue Shield contracts have been liberalized by extending coverage to ill children from birth, and by increasing the time limit on emergency care to 72 hours.

Constant endeavor to improve and advance Blue Shield is being carried on by organized medicine at all levels, by the National Association of Blue Shield Plans, and by the local Plans themselves. Continuous research is being conducted. Both the American Medical Association and the Florida Medical Association not only have taken positive stands for voluntary nonprofit Plans, but have backed their words with action. Last November the House of Delegates of the American Medical Association directed its Board of Trustees and its Council on Medical Service to assume immediate leadership in consolidating the efforts of the American Medical Association with the National Association of Blue Shield Plans, the American Hospital Association and the Blue Cross Association.

The Florida Medical Association is equally on record in support of its own Blue Shield Plan. Its Committee of Seventeen devotes long, tedious, gratuitous hours to the consideration of proposed contracts and schedules of benefits. At the Jacksonville office of Blue Shield a professional research analyst is assigned exclusively to the task of providing the factual information which will lead to still further progress in all phases of Blue Shield activity.

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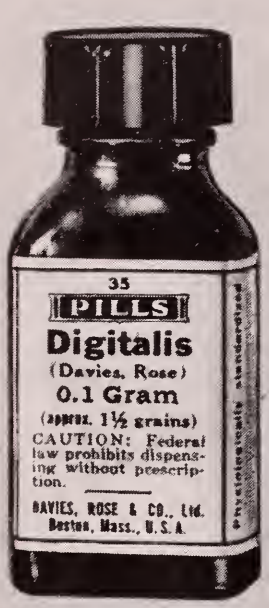
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STATE NEWS ITEMS

Dr. Francis T. Holland of Tallahassee and the Florida Medical Association have been recognized for almost a decade of service to the Department of Public Safety for assistance in its driver licensing program. Dr. Holland is chairman of a committee of physicians located in various sections of the state who work with the Florida Highway Patrol and the Department on special medical problems relating to the physical and mental conditions concerning persons operating motor vehicles. In recognition of this service, Governor Farris Bryant presented a certificate to Dr. Holland on behalf of the Department.

Dr. Henry I. Langston of Apalachicola has been chosen president-elect of the Florida Association of County Health Officers. He is director of the health units in Franklin, Gulf and Wakulla counties.

Dr. Franklin J. Evans of Coral Gables has been elected to the city commission at Coral Gables.

Drs. Robert B. McIver, Jack Galin, William A. VanNortwick, J. Harold Newman and William M. Hutchinson of Jacksonville were among the group of Florida physicians attending the meeting of the Southeastern Section of the American Urological Association held at Hollywood.

Dr. Kermit H. Gates of Coral Gables has been honored by the University of Miami School of Medicine in appreciation of his assistance in a six year program of education in esophageal speech for laryngectomized patients.

Dr. A. W. Sweat, a member of the first class of graduates of the University of Florida College of Medicine in Gainesville, has been named a recipient of a 1961 Mead Johnson Award for general practice. Dr. Sweat is interning at Salt Lake County General Hospital in Salt Lake City, Utah. In July, he plans to begin a residency in general practice at Mound Park Hospital at St. Petersburg.

(Continued on page 1378)

from mental confusion to the right frame of mind



continuous, 24-hour cerebral oxygenation for the aging patient. By stimulating respiratory and circulatory function, GERONIAZOL TT* relieves mental confusion, depression, anxiety, and emotional instability—frequent problems in patients after forty—due to presenile changes in the vasculature of the brain. Notable benefit usually is seen within one to three weeks of therapy. It improves appetite, sleep pattern, and outlook—and GERONIAZOL TT* is non-hypertensive, non-excitatory.

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References: 1. Curran, T. R., and Phelps, D. K.: Am. Pract. & Dig. Treat. *11:* 617, 1960. 2. Levy, S.: J.A.M.A. *153:* 1260, 1953. 3. Connolly, R.: W. Va. Med. J. *56:* 263, 1960.



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You will find this book invaluable for treating patients with elevated serum cholesterol.

Complete menus for 10 days enable you to prescribe diets which are appetizing, nutritiously adequate and which can exert cholesterol depressant activity. Special attention has been given to constructing the menu patterns so that they adhere as closely as permissible to the patient's normal eating habits.

NRC Standards fulfilled. Each menu has been calculated to provide the proper daily allowance of proteins, vitamins and other nutrients as recommended by the Food and Nutrition Board of the National Research Council.

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Variety and appetite appeal for patient are built into the menu plan to an extent not previously accomplished. Alternate choices for main dishes minimize monotony, encourage the patient to follow closely the menu plan you specify.

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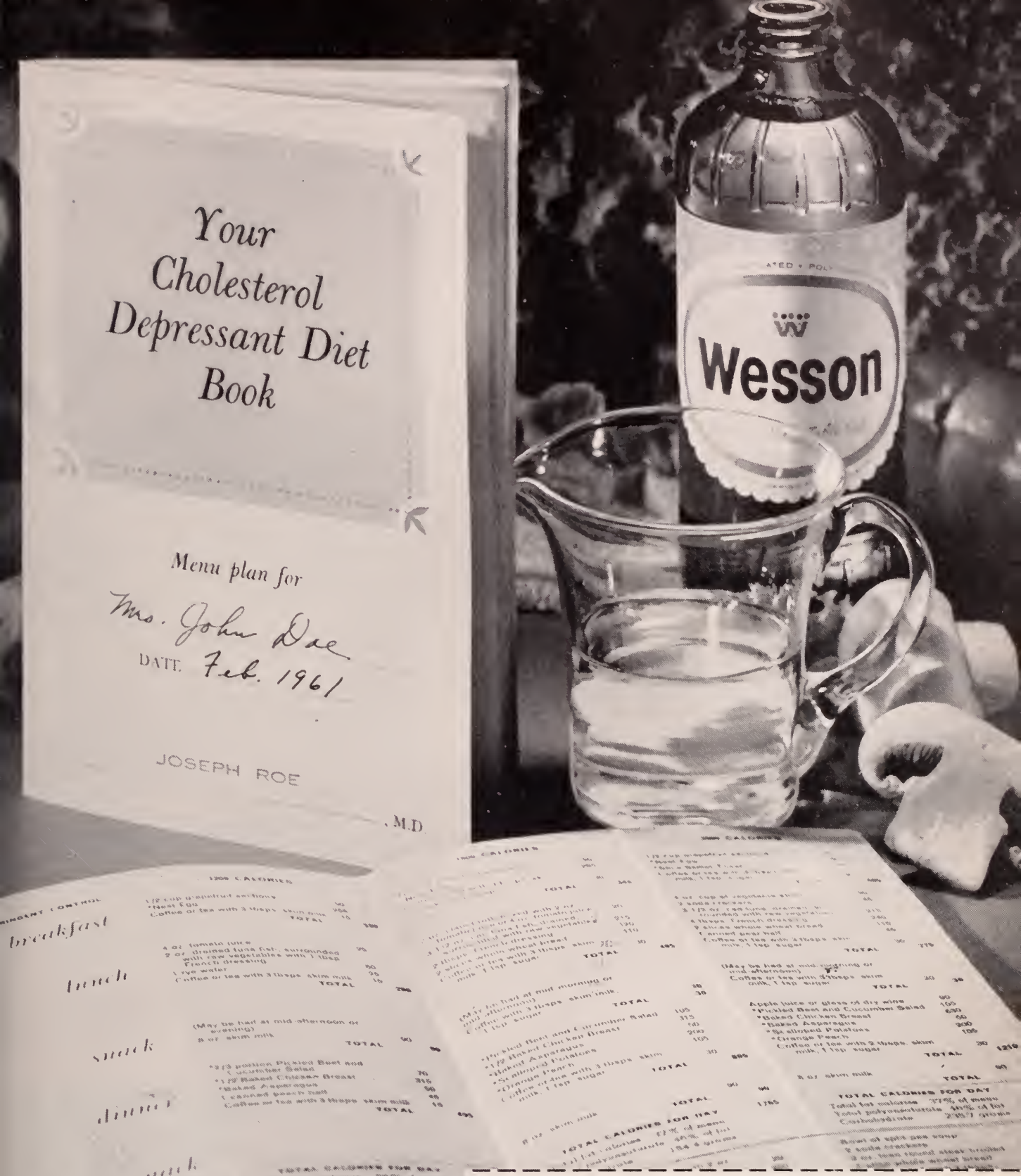
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(Continued from page 1374)

Among Florida physicians participating in the Tenth Anniversary Clinical Meeting of the American College of Obstetricians and Gynecologists held April 20-28 at Bal Harbour, Miami Beach, were Dr. E. Frank McCall of Jacksonville, and Drs. Ralph W. Jack, James H. Ferguson, Eduardo F. Pena, and John G. Maclure of Miami, and Dr. John D. Milton of Coral Gables.

Close to $4 million in research funds have been allocated to the University of Miami School of Medicine this year, according to the quarterly report of the dean. Major granting agency at the present time is the National Institutes of Health. Other agencies which have provided funds are the American Cancer Society, the John A. Hartford Foundation, the American Heart Association, and the pharmaceutical companies Wyeth, Lederle, Winthrop and Wallace.

Dr. Leon S. Eisenman of Hialeah has been elected president of the Hialeah Industrial Lions Club for the year 1961-1962.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Active

Allen, Frederick K., Bradenton
Boudreau, Robert F., Fort Myers
Burford, Fred J., Fort Myers
Cammarata, John M., Key West
Center, Sol, Miami
Dakos, William N., Fort Myers
David, Theodore A., Fort Myers
Drlicka, Albert V., Pensacola
Dunham, Charles T., St. Petersburg
Edwards, Ralph, Miami
Faust, William R., Tampa
Giles, Roy S., Fort Myers
Goza, George M. Jr., Cocoa
Guyton, Thomas B., S. Miami
Horwitz, Michael L., Miami Beach
Justiz, Charles T., Miami
Kitaif, James C., Palatka
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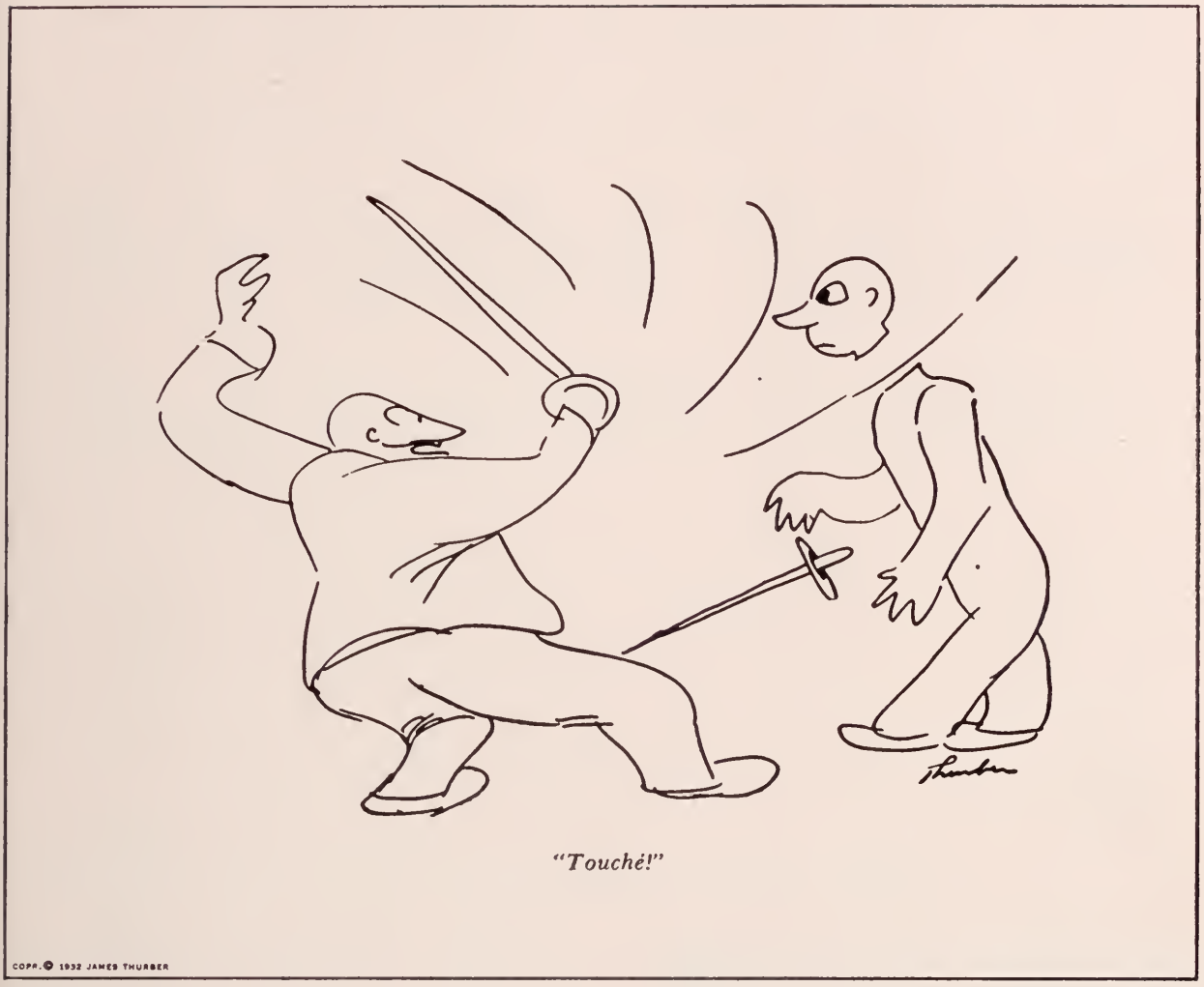
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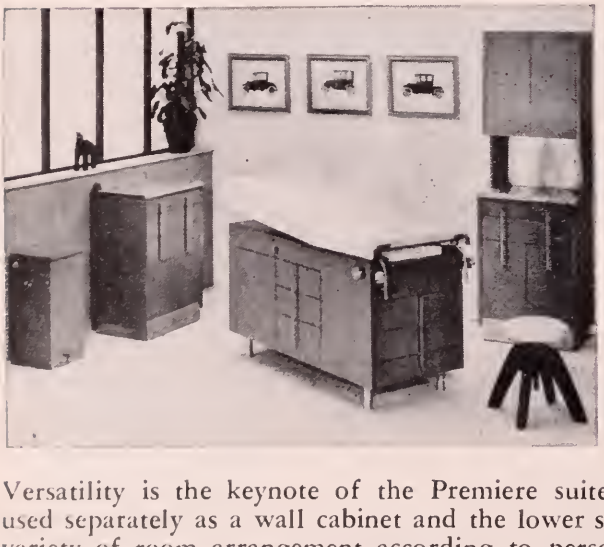
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(Continued on page 1385)

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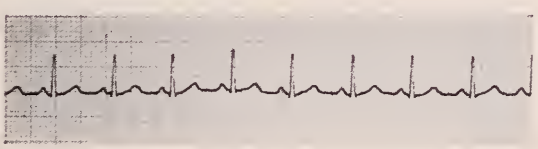
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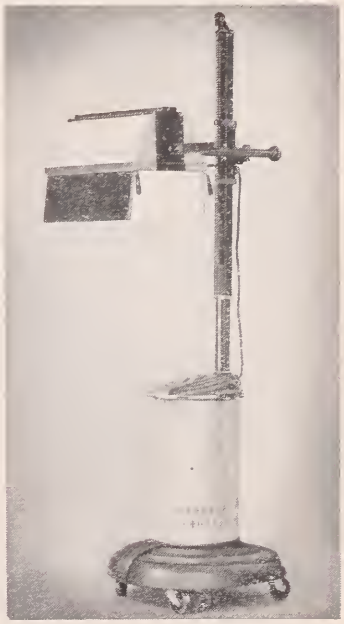
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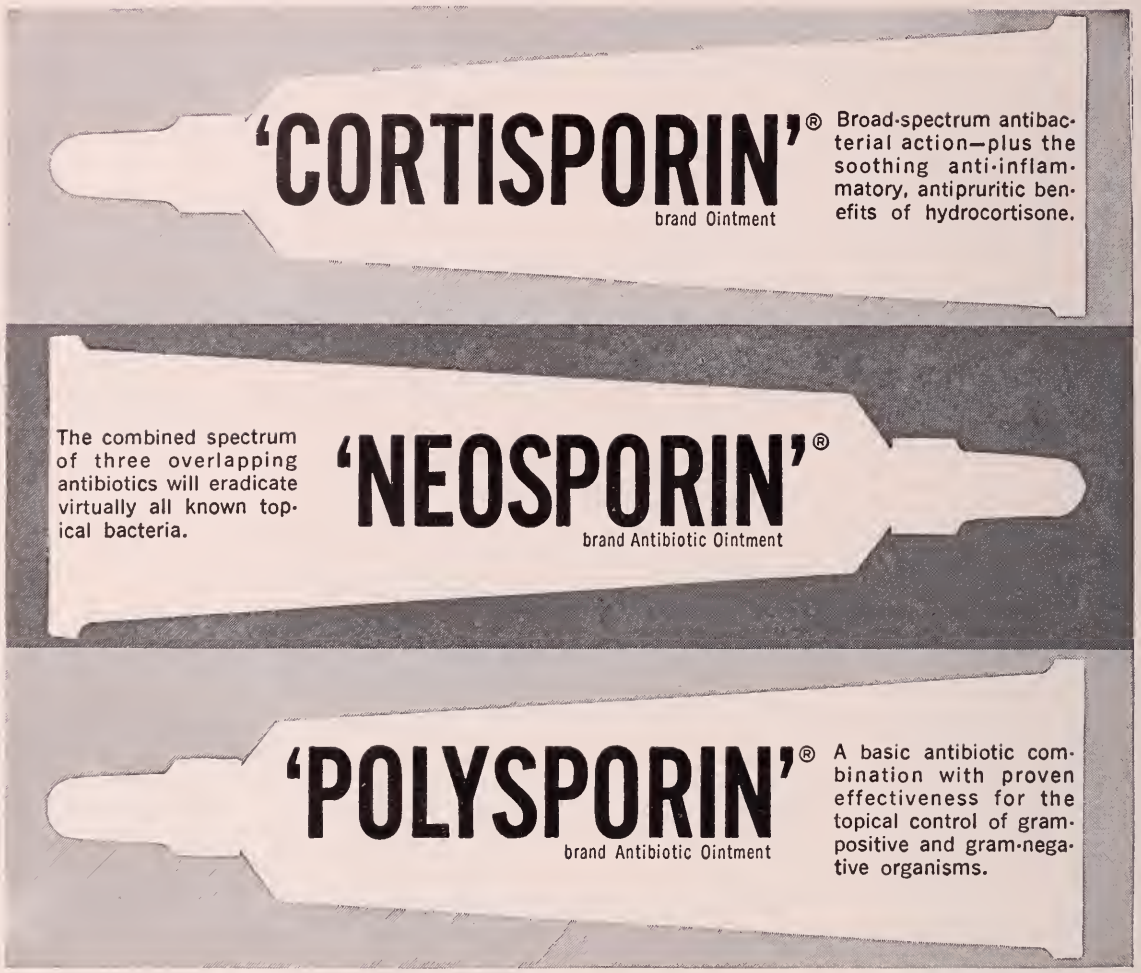
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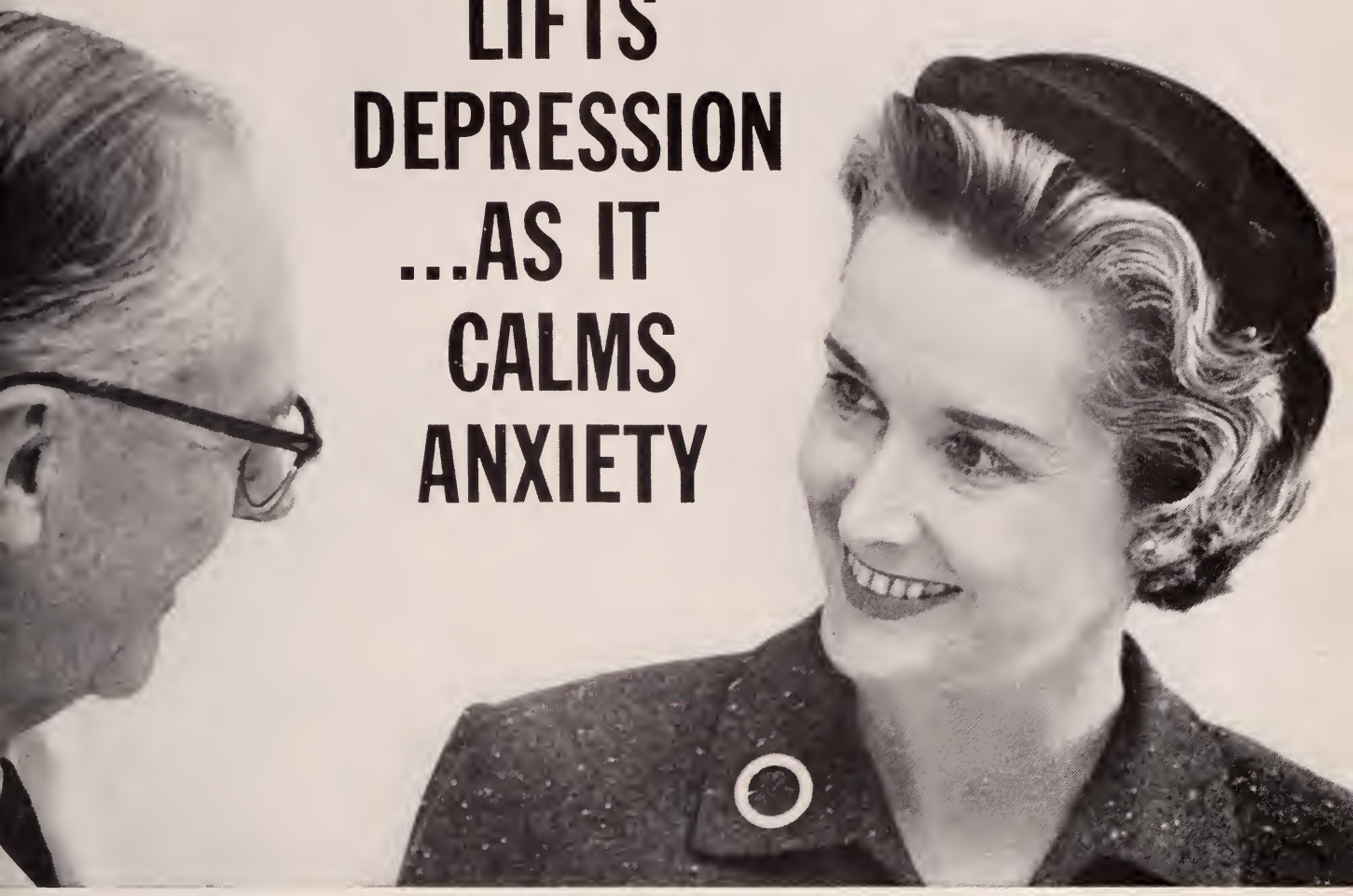
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When ARISTOCORT was given to patients with dermatologic disorders for long periods, there were no significant changes in blood pressure. (Kanof, N. B.; Blau, S.; Fleischmajer, R., and Meister, B.: *A.M.A. Arch. Dermat.* 79:631 [June] 1959.)

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Ideally, corticosteroid therapy ought not to add to the psychic component in dermatologic disorders, nor induce insomnia which will intensify the patient's itching and irritation. ARISTOCORT Triamcinolone has been singled out for its remarkably low incidence of psychic irritation and insomnia. (McGavack, T. H.: *Nebraska M. J.* 44:377 [Aug.] 1959; Freyberg, R. H.; Berntsen, C. A., Jr., and Hellman, L.: *Arthritis & Rheumatism* 1:215 [June] 1958.)

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Elderly patients with pulmonary emphysema due to impending heart failure who required corticosteroid therapy showed that triamcinolone could be employed with benefit and relative safety. (McGavack, T. H.; Kao, K. Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 [Dec.] 1958.)

Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. In the treatment of allergic and inflammatory dermatoses, dosage should be individualized and kept at the lowest level needed to control symptoms. Dosage should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

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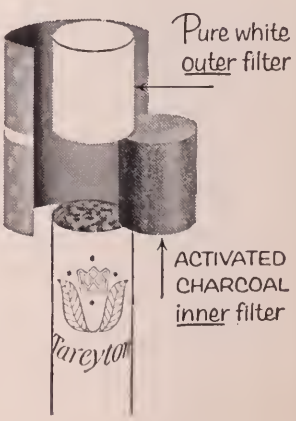
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Wednesday, June 14, 1961
The Schine Inn

CHEYENNE, WYOMING
Monday, July 24, 1961
The Plains Hotel

McALESTER, OKLAHOMA
Saturday, July 29, 1961
The Aldridge Hotel

SEATTLE, WASHINGTON
Saturday, August 5, 1961
The Olympic Hotel

KANSAS CITY, KANSAS
Friday, September 15, 1961
Battenfeld Memorial Auditorium

TOLEDO, OHIO
Thursday, September 28, 1961
The Commodore Perry Hotel

WICHITA, KANSAS
Wednesday, October 4, 1961
The Broadview Hotel

TRAVERSE CITY, MICHIGAN
Friday, October 13, 1961
The Park Place Hotel

PEORIA, ILLINOIS
Thursday, October 26, 1961
The Hotel Pere Marquette

PROVIDENCE, RHODE ISLAND
Wednesday, November 1, 1961
The Colony Motor Hotel

HARRISBURG, PENNSYLVANIA
Thursday, November 9, 1961
The Penn Harris Hotel

JACKSONVILLE, FLORIDA
Sunday, November 12, 1961
The Robert Meyer Hotel

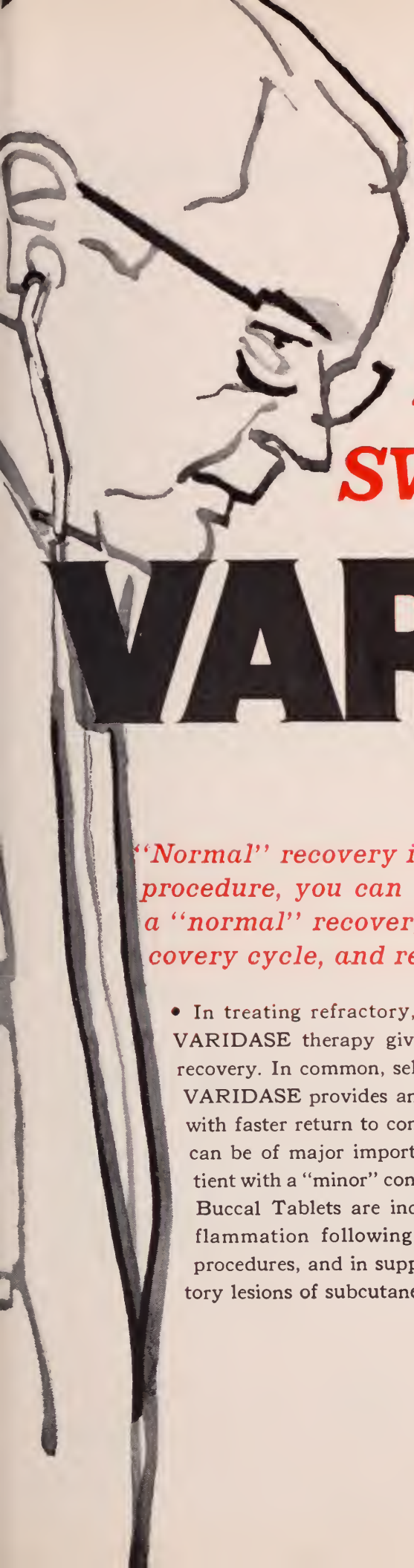
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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L.: Lahey Clinic Bull. 11:12 (July-Sept.) 1958

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T. C. C.: in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan, G. G.: Diseases of Metabolism, 4th edition, W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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OBITUARIES

Elmer B. Campbell Sr.

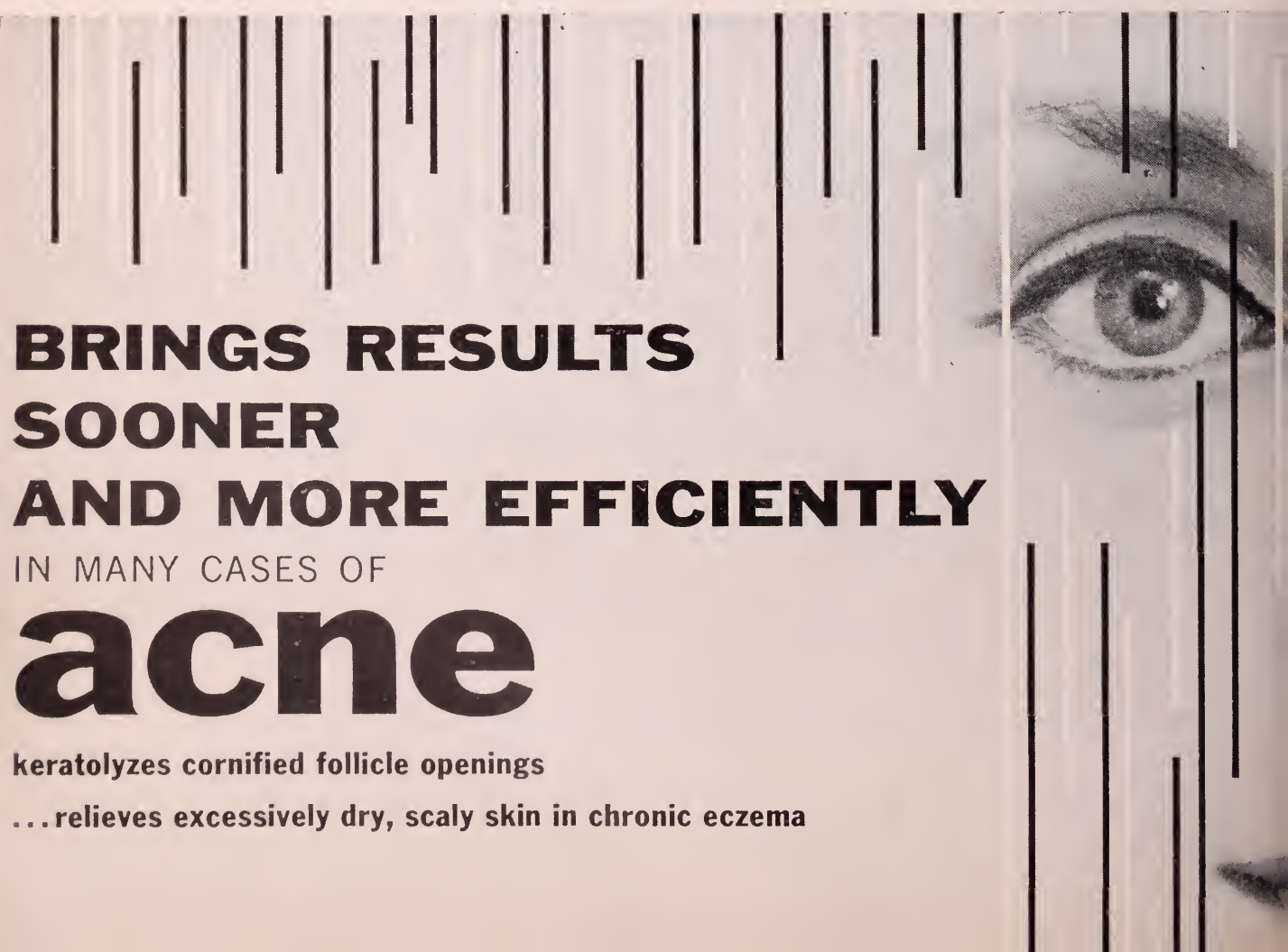
Dr. Elmer B. Campbell Sr. died at his home in St. Petersburg on Dec. 6, 1960. He was 68 years of age.

Dr. Campbell was born at Albertville, Ala., on Nov. 2, 1892, and received his early schooling and academic education in his native state. Upon graduation from Alabama Polytechnic Institute at Auburn, he received his medical training at Emory University School of Medicine. Graduating as president of his class, he was awarded the degree of Doctor of Medicine by that institution in 1923. He served an internship at Grady Hospital in Atlanta and had further postgraduate training at the United States Steel Hospital in Birmingham, Ala.

His service with Veterans Administration hospitals brought Dr. Campbell to Florida. In 1932 he was put in charge of the receiving service at the Veterans Administration Hospital in Milwaukee, Wis., and in 1939 he came to the Bay Pines Veterans Administration Center near St. Petersburg in that same capacity. The following year he entered the private practice of medicine in St. Petersburg and continued to practice there through the years. He was on the medical staff of St. Anthony's Hospital and Mercy Hospital and served as a medical adviser to the State Vocational Rehabilitation Department. During World War I, he served as an artillery captain at Second Army Headquarters in France. Locally, he was a Mason and a member of American Legion Post 13. He held membership in the First Baptist Church, the Chamber of Commerce, the St. Petersburg Tennis Club.

Dr. Campbell was a member of the Pinellas County Medical Society, the Florida Medical Association, the American Medical Association and the Southern Medical Association. He also was a member and at the time of his death the president of the Florida Academy of General Practice, and a member of the American Academy of General Practice.

Surviving are the widow, Mrs. L. Elizabeth Sayer Campbell, a daughter, Mrs. William R. Davenport, and a son, Dr. Elmer B. Campbell Jr., all of St. Petersburg; two brothers, William Campbell and Preston Campbell, and a sister, Mrs. Emma Casey, all of Alabama; and two grandchildren.



Dodge Dustin Mentzer

Dr. Dodge Dustin Mentzer of Largo died at his home on Dec. 16, 1960. He was 46 years of age.

A native of Columbus, Ohio, where he was born in 1914, Dr. Mentzer received his medical training at the Medical College of Georgia in Augusta. Upon graduation in 1945, he served an internship at Emory University Hospital. He was licensed to practice in Florida in 1947 and located in Lakeland. After practicing there for 11 years, he moved to Largo and had practiced for three years at the Midway Medical Center in Seminole. During World War II he served as a captain in the Army Medical Corps. He was a member of the First Presbyterian Church in Lakeland.

Dr. Mentzer was a member of the Polk County Medical Association and had applied for membership in the Pinellas County Medical Society. He was also a member of the Florida Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Geraldine Mentzer, of Largo; three daughters, Sussane Mentzer, of Gainesville, Elizabeth Mentzer of Largo, and Caroline Mentzer, of Lakeland; one son, Dodge D. Mentzer Jr., of Lakeland; two step-sons, John Martin Harrell III and Richard Harrell, both of Lakeland; his parents, Mr. and Mrs. Max Mentzer, of Lake Worth; and one brother, Richard Mentzer, also of Lake Worth.

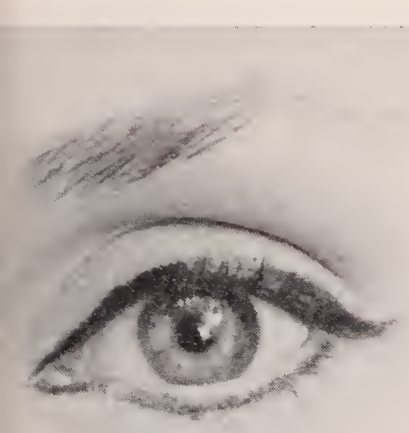
Elizabeth May Knott

Dr. Elizabeth May Knott died at her office in Ridge Manor on Dec. 7, 1960. She was 58 years of age. Interment took place in Antigo, Wis.

A native of Wisconsin, Dr. Knott was born in Antigo on Feb. 6, 1902. She received her medical training at the University of Wisconsin Medical School, where she was awarded the degree of Doctor of Medicine in 1943. She located in Ridge Manor in mid-1959 after practicing pediatrics in Hialeah for eight years. She had formerly lived in New York City. Locally, she was a member of the Church of Ridge Manor and of the Fellowship Guild and was also a member of the Soroptimist Club of Brooksville.

Dr. Knott was a member of the Pasco-Hernando-Citrus County Medical Society, the Florida Medical Association, the American Medical As-

(Continued on page 1404)



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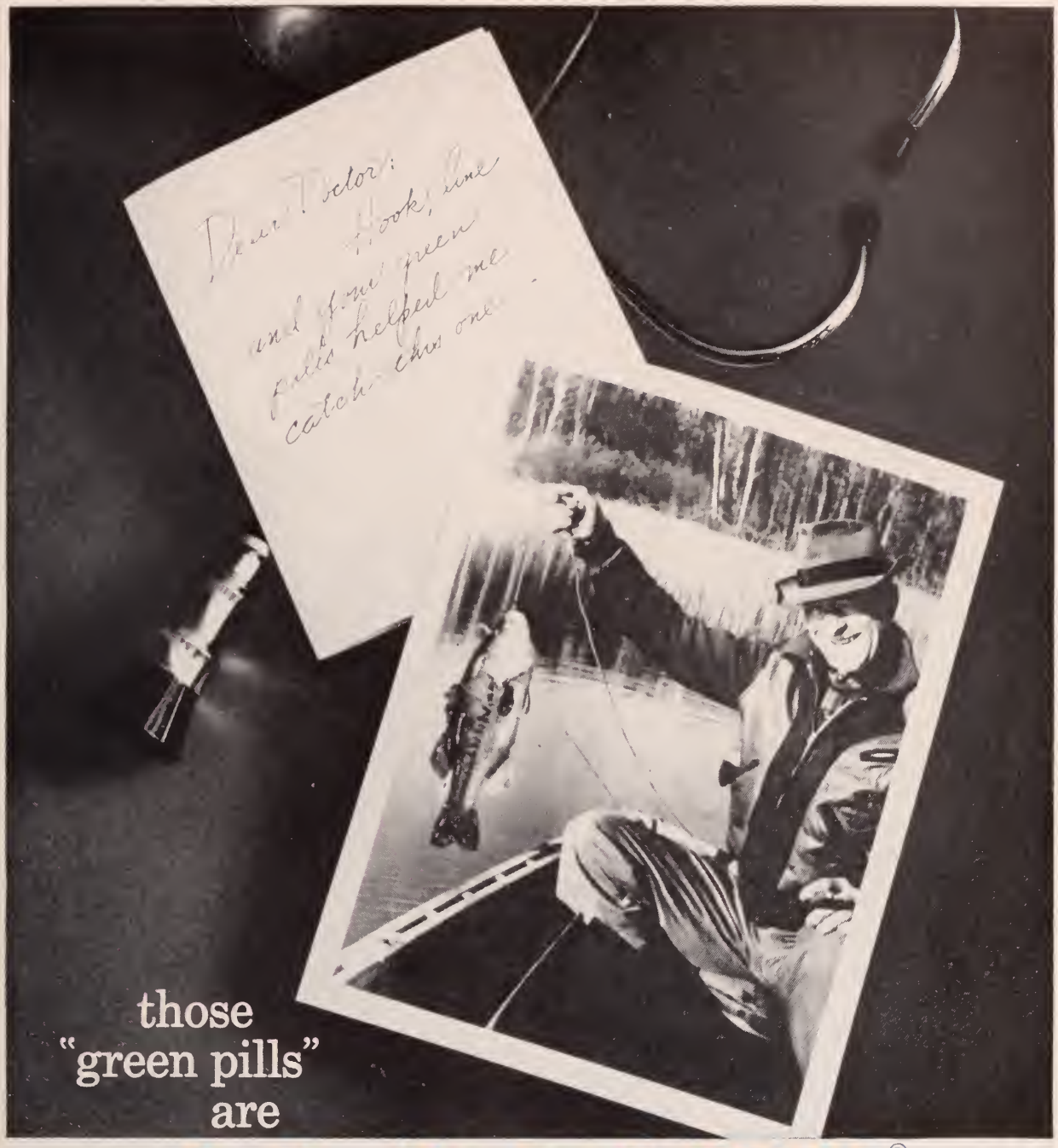
It was found that as little as 3 ounces of a California Burgundy could lower the emotional tension index in normal humans exposed to controlled conditions of extreme stress.

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*Silverman, M.: 48th Quarterly Meeting, Soc. Medical Friends of Wine, Jan. 13, 1960



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(Continued from page 1401)

sociation and the Southern Medical Association. She also held membership in the Florida Pediatric Society, the American Academy of Pediatrics and the American Academy of General Practice.

Dr. Knott is survived by a brother, William Morgan Knott, of Titusville, and a niece, Patricia M. Howe, of Ridge Manor.

BOOK REVIEWS

Edema: Mechanisms & Management. *A Hahnemann Symposium on Salt and Water Retention.* Edited by John H. Moyer, M.D., and Morton Fuchs, M.D. Pp. 833. Illus., 286. Price, $15.00. Philadelphia, W. B. Saunders Company, 1960.

No treatise on such an extensive and currently intensely studied subject as edema could be called complete, but this book reaches very close. It is the most comprehensive and authoritative text this reviewer has seen so far, and its contents should satisfy the needs of internists, surgeons and all investigators and clinicians in every field of medicine.

The contributions derive from the Hahnemann Symposium on Salt and Water Retention held late in 1959 by about 90 authorities. Well edited summaries of the panel discussion add interest to the numerous papers dealing with all possible aspects of the problem under 112 titles.

A review of the basic physiology bearing on water and electrolyte distribution as it is related to edema is presented in the initial chapters of the book providing a clear understanding of the individual clinical syndromes. The pharmacology and clinical use of the diuretic agents are then presented with emphasis on the most recent advances and on the current lines of research.

The various clinical syndromes in which edema is an important feature are discussed in detail in the latter part of the book. The inclusion of the panel discussions adds great interest as well as information regarding authoritative opinions, agreements and disagreements on various phases of the subjects reviewed.

This book is definitely a MUST in any consulting medical library and at the hand of those who wish to keep themselves abreast and well informed on the subject of edema.

C.P.L.

Current Surgical Management II. *A Book of Alternative Viewpoints on Controversial Surgical Problems.* Edited by John H. Mulholland, M.D., Edwin H. Ellison, M.D., and Stanley R. Friesen, M.D. Pp. 348. Illustrated. Price, $8.00. Philadelphia, W. B. Saunders Company, 1960.

Texts written by a single author may present a biased knowledge of the subject with possible limited points of view. This volume of Current Surgical Management II abolishes such an impractical stand. Fifty experienced authorities harboring various opinions contribute to this excellent surgical treatise. They prove that surgeons remain students throughout their life span. Sixteen surgical topics of controversial nature are presented in the order of their problematic occurrence instead of the usual regional anatomical distribution.

The text fits into our current method of medical education and should be of utmost value to the resident-in-training who is constantly grasping for knowledge to stabilize his uncertainty. It is strongly recommended to the pre-examinee who is preparing for his board examinations because these are the exact problems he faces from the examiners. The contents should also be of value to the surgeon who practices in a small community which depends upon him for its entire care, and the usual

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vacation or postgraduate course comes as a premium. Certainly not least, the teacher could profit by reading some of the material in this outline and compare it with his own teachings.

The editors, Mulholland, Ellison and Friesen, are known and respected by all of us. This book is another example of their unselfishness to our profession. Comparing the price with the contents, it is suggested as a reading item to all men preparing for or in the surgical profession.

Clifford C. Snyder, M.D.

W. B. Saunders Company features the following books in its advertisment in this issue: White—Clinical Disturbances of Renal Function; Rubin—Thoracic Diseases, and Mayo Clinic—Diet Manuel.

Clinical Management of Behavior Disorders in Children. By Harry Bakwin, M.D., and Ruth Morris Bakwin, M.D. Ed. 2. Pp. 597. Illustrated. Price, $11.00. Philadelphia, W. B. Saunders Company, 1960.

In recent years physicians have become increasingly interested in the psychological aspects of child care. Bakwin and Bakwin's book is an excellent practical guide for every physician who treats children. It offers usable, common sense management recommendations for difficulties ranging from breast feeding to antisocial behavior. It is written with a stronger medical than psychodynamic approach. Recognition of the normal and abnormal variations in social and motor behavior is stressed. The realization of the uniqueness of each child is also noted. The wide range of material includes growth and development, psychological care at different periods, care of the ill and handicapped, and the etiology, diagnosis and treatment of behavior problems and mental and emotional disorders.

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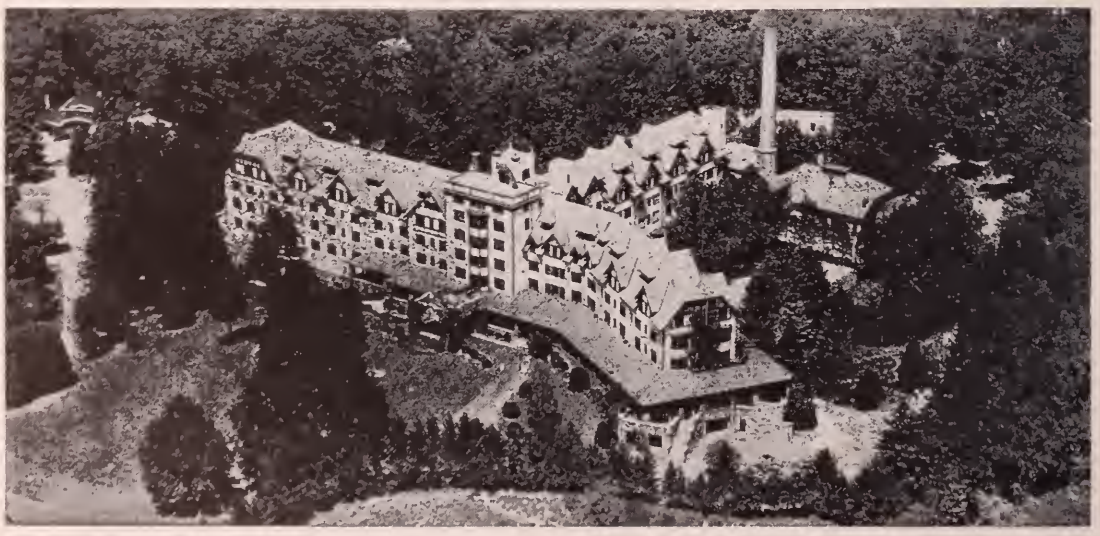
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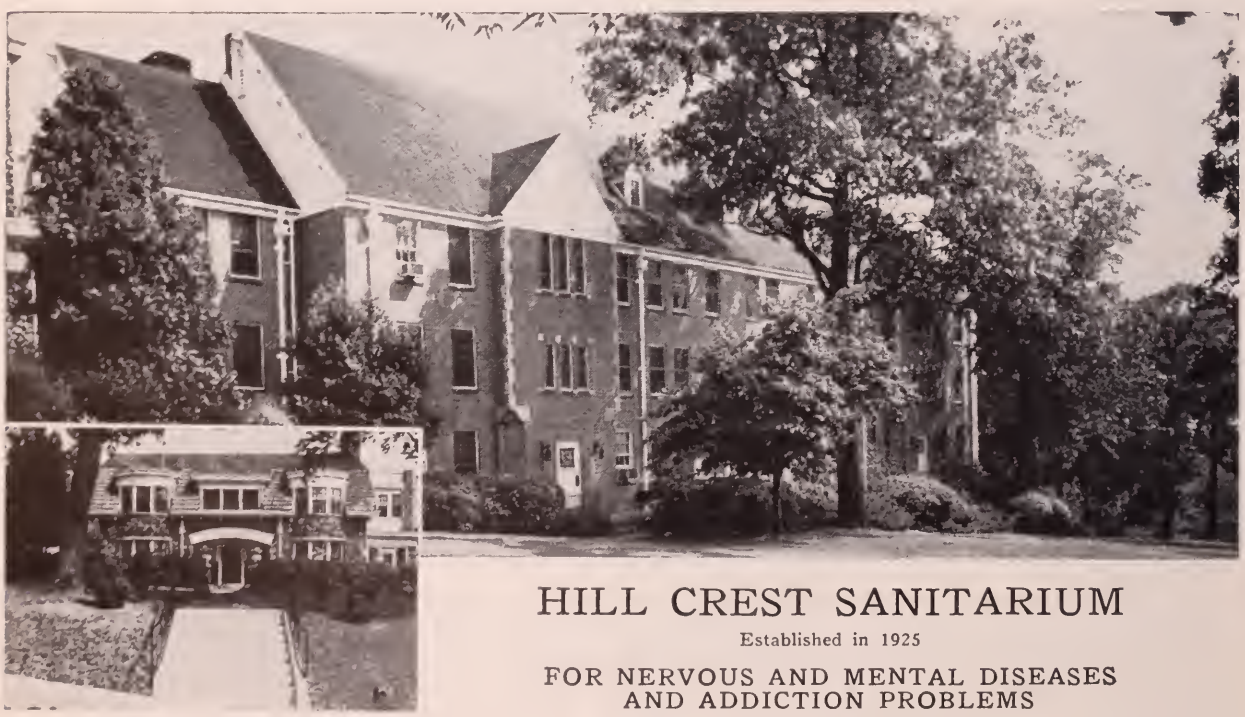
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1. Clein, N. W.: Pediat. Clin. North America, Nov., 1954, pp. 949-962.

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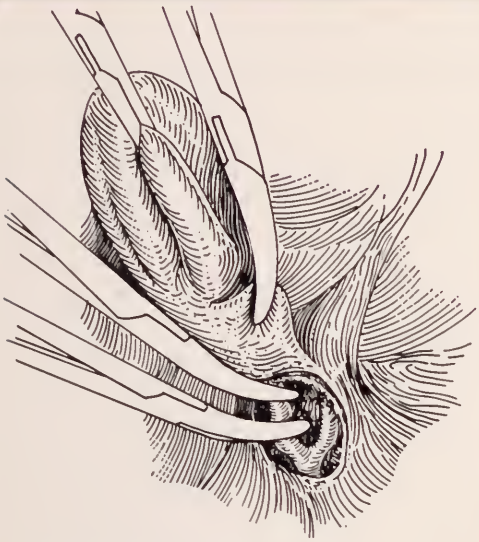
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references: (1) Lish, P. M.; Albert, J. R.; Peters, E. L., and Allen, L. E.: Arch. internat. pharmacodyn. *129*:77-107 (Dec.) 1960. (2)Howell, C. M., Jr.: North Carolina M. J. *21*:194-195 (May) 1960. (3) Clinical Research Division, Mead Johnson & Company. (4) Wahner, H. W., and Peters, G. A.: Proc. Staff Meet. Mayo Clin. *35*:161-169 (March 30) 1960. (5) Crepea, S. B.: J. Allergy *31*:283-285 (May-June) 1960. (6) Crawford, L. V., and Grogan, F. T.: J. Tennessee M. A. *53*:307-310 (July) 1960. (7) Spoto, A. P., Jr., and Sicker, H. O.: Ann. Allergy *18*:761-764 (July) 1960. (8) Arbesman, C. E., and Ehrenreich, R.: New York J. Med. *61*:219-229 (Jan. 15) 1961.

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